MONTGOMERY COUNTY COUNCIL

FY 02 INTENSIVE BUDGET REVIEW PROJECT # 7

ALCOHOL, TOBACCO, AND OTHER DRUG PREVENTION PROGRAMS FOR SCHOOL-AGE YOUTH

OFFICE OF LEGISLATIVE OVERSIGHT

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EXECUTIVE SUMMARY

Alcohol, tobacco, and other drug (ATOD) use among Montgomery County students, as among students State and nationwide, peaked in the mid-1990's. Since 1998, alcohol and cigarette use by County students declined, in some age cohorts by more than 10 percent.

While recognizing progress has been made, 2001 survey data show significant numbers of County high school students drink alcohol, smoke cigarettes, and use marijuana. Alcohol is the illegal substance most commonly used by school-age youth. Of County 12th graders surveyed in 2001, 66% self-report having ever tried some form of alcohol; 44% drank during the past 30 days; and 28% had five or more servings of alcohol on the same occasion during the past 30 days.

Over the past 20 years, the County has committed significant staff and funds to addressing substance abuse issues. Agencies involved with prevention activities for school-age youth are the Public Schools, four County Government departments (Health and Human Services, Police, Recreation, and Community Use of Public Facilities), the Housing Opportunities Commission, Office of the Sheriff, and M-NCPPC Park Police.

Across agencies, more than 30 programs cite substance abuse prevention as a primary goal and at least 10 standing committees deal with prevention issues. The County also has a Prevention Coordinator, who is part of the State Alcohol and Drug Abuse Administration's Statewide Prevention Network.

In FY 02, the Council appropriated $6.74 million to support these programs. About $2 million (30%) of this money was non-County funds, primarily state and federal grants. With a few notable exceptions, the agencies' FY 03 budget requests propose same services funding for prevention activities. Across agencies, FY 03 budget requests for prevention programs total $6.58 million, which is $161K (2%) less than FY 02.

Of the $6.7 million spent during FY 02 on prevention programs for school-age youth:

- $4.2 million (63% of total) went to universal prevention programs designed for all youth - this includes classroom prevention education by MCPS teachers, the 5th grade DARE program taught by law enforcement officers, alternative activity programs for teens during "at risk" hours, and many Safe and Drug Free School Project activities.

- $1.9 million (29% of total) went to selective prevention programs targeted for subgroups of youth at higher risk – this includes programs for families in HOC's public housing complexes, the Police Activities League, MCPS' Student Assistance Program (part of Safe and Drug Free Schools Project), and DHHS' Screening Assessment Services for Children and Adolescents.

- $0.5 million (8%) went to indicated prevention programs administered by MCPS and DHHS. Indicated programs target high-risk individuals who are already substance users or who exhibit behaviors or whose living circumstances put them at notably higher risk for ATOD use and/or addiction.

Much research has been conducted during the past 20 years about what constitutes an effective substance abuse prevention program. No single prevention program is the "best" and no one program will stop all drug use. The most effective programs begin early and continue through adolescence when young people face more immediate challenges. Positive outcomes increase if prevention programs influence young people at school, at after-school activities, at home, and in the community. Model programs proven effective by scientific research are now identified for many (although not all) prevention strategies.

The County's prevention activities generally parallel the types of strategies identified by the Center for Substance Abuse Prevention. In fact, two programs adopted four years ago as part of MCPS' middle school health curriculum (Project ALERT and Project TNT) are model programs identified by the Center for Substance Abuse Prevention as "effective."

It is tempting to conclude that reported declines in alcohol and tobacco use among County youth in recent years result directly from the County's investment in prevention activities. However, here as in communities across the country, the data do not exist to quantify a cause-and-effect link between specific ATOD prevention activities and ATOD use rates in the County.

In three facilitated work sessions convened by OLO as part of this study, staff from the agencies involved with prevention all voiced a need for improved communication and coordination. Worksession participants also expressed strong interest in making decisions based upon knowledge of what is effective.

The Office of Legislative Oversight's specific recommendations to the Council are:

- To address substance abuse prevention for school-age youth as a priority inter-agency issue;
- To establish two-year and five-year goals for substance use reduction among the County's youth;
- To facilitate the establishment of a single, senior policy level group to coordinate prevention activities across the agencies; and
- To set a long-term policy goal of appropriating funds only to prevention programs and strategies for which there is science-based evidence of effectiveness.

In terms of FY 03 budget decision-making, OLO advises the Council to follow three principles: balance funding among universal, selective, and indicated programs; place priority on funding programs with proven effectiveness; and do not spend County funds on activities for which outside funds are available.

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This report, prepared by the Office of Legislative Oversight, is one of seven FY 02 Intensive Budget Review (IBR) projects approved by the Council in July 2001. These seven projects received the largest number of priority "points" in Councilmembers' rankings of potential projects. The Council's intent is to provide its members with more comprehensive information and options related to decision-making on the FY 03 and future operating budgets.[1]

A. Project Scope

Each year, the Council appropriates funds among multiple agencies to support a range of activities aimed at preventing alcohol, tobacco, and other drug use (ATOD) and abuse. The funding sources for these activities come from a combination of County tax dollars and outside funds, primarily federal and state grants.

The focus of this IBR project is an analysis of ATOD prevention programs and activities whose target audience is school-age youth Pre-K through 12th grade. This includes:

- Compiling an inventory that identifies the cost, and sources of funding for ATOD prevention programs and activities for which the Council appropriates County and non-County funds;

- Identifying the strengths of collective efforts and opportunities for improving the coordination and effectiveness of County-supported ATOD prevention activities; and

- Advising the Council on how to approach FY 03 and future funding decisions on ATOD prevention programs and activities.

To assist the Legislative Branch staff in these tasks, the scope of this project included a series of facilitated meetings among key representatives from the County-funded agencies currently engaged in ATOD prevention.

This IBR project also is intended to serve as a building block for a comprehensive review of the County's system of substance abuse prevention and treatment for adults and juveniles that the Council's Health and Human Services Committee and Public Safety Committee decided last year to undertake.

[1] IBR projects staffed by OLO were also listed in Council Resolution No. 14-965, *FY 2002 Work Program of the Office of Legislative Oversight,* adopted July 24, 2001.

B. Organization of Report

Chapter II: Alcohol, Tobacco, and Other Drug Use Among School-Age Youth summarizes data from the Maryland Adolescent Survey on the rates of alcohol, tobacco, and other drug use and abuse among school-age youth in Montgomery County, and compares County data to state and national data.

Chapter III: Substance Abuse Prevention: What Works? describes the emerging science of substance abuse prevention, summarizes the lessons learned from empirical research, and presents information on federal government efforts to disseminate information about effective substance abuse prevention programs.

Chapter IV: Background on County Prevention Activities provides a brief history of the County's earlier efforts to examine and coordinate ATOD prevention programs and activities across agency lines. This chapter also describes the standing committees and other groups established to coordinate one or more aspects of substance abuse prevention.

Chapter V: Prevention Programs for School Age Youth in Montgomery County: FY 02 Inventory and Fiscal Analysis presents descriptive and fiscal information on the ATOD prevention programs for which the Council appropriated or approved funds in FY 02; summary program information is provided in a number of different ways.

Chapter VI: FY 03 Agency Budget Requests reviews how the agencies' FY 03 budget requests propose changes to the FY 02 inventory and/or funding of ATOD prevention programs for school-age youth.

Chapter VII: Measuring the Performance of Prevention Programs in the County discusses the role of the Maryland Adolescent Survey in measuring the effectiveness of the County's ATOD prevention programs and summarizes performance measures currently collected and reported.

Chapter VIII: Results of Inter-Agency Worksessions explains both the process and results of the three inter-agency worksessions convened as part of this IBR project.

Chapters IX and X: Findings and Recommendations of OLO staff.

C. Acknowledgements

The Office of Legislative Oversight thanks the many agency staff who contributed to this IBR report. Compiling data across department and agency lines is always challenging and this project was only possible because of the tremendous cooperation we received from multiple program and budget staff from the Montgomery County Public Schools, County Government Departments of Health and Human Services, Police, Recreation, and Community Use of Public Facilities; Housing Opportunities Commission; Office of the Sheriff, and M-NCPPC.

OLO greatly appreciates the time and valuable contributions made by the individuals who participated in our three inter-agency worksessions. A list of participants is attached in Appendix P. In addition, OLO thanks central Council staff members Linda McMillan and Essie McGuire for the technical assistance they provided to OLO staff throughout the IBR project study period.

D. Definitions—What Is Prevention?

Alcohol, Tobacco, and Other Drug Prevention Program: No universal definition of *substance abuse prevention* exists. This IBR project, however, limited itself to programs and activities that have as a primary goal to delay, reduce, and/or prevent altogether alcohol, tobacco, and/or drug use among school age youth.

Many state and local governments have adopted some variation of the **Center for Substance Abuse Prevention's** (CSAP) definition of prevention, which is:

> Prevention is a proactive process. It empowers individuals and systems to meet the challenges of life events and transitions by creating and reinforcing conditions that promote healthy behaviors and lifestyles.

The State of Maryland's Alcohol and Drug Abuse Administration (ADAA) defines prevention as "the creation of conditions, opportunities, and experiences, which encourage and develop healthy, self-sufficient people."

The Maryland Association of Prevention Professionals (MAPP) elaborates on ADAA's definition:

> Based on more than 20 years of rigorous research, a science of alcohol, tobacco, and other drug abuse prevention is now emerging. Prevention aims to forestall behavior or render it impossible rather than taking corrective action later. Law enforcement and treatment are important partners with prevention in implementing comprehensive community strategies across all three domains. (Maryland Association of Prevention Professionals and Advocates, December 2000)

A draft Montgomery County Government policy on the prevention of alcohol, tobacco, and other drug abuse (prepared in 1993, but never formally adopted by the County Executive or County Council) defined prevention as follows:

> Montgomery County defines prevention as a multifaceted, proactive process, which empowers individuals and systems to meet the challenges of life events and transitions. It does this by creating and reinforcing conditions that promote healthy behaviors and lifestyles. Prevention related specifically to alcohol, tobacco, and other drug abuse is defined as a set of procedures, programs and services designed to reduce the incidence of substance abuse and related problems of individuals, families and communities. (Draft policy attached to September 30, 1993, memorandum to DHHS Director.)

The federal government's **Office of Juvenile Justice and Delinquency Prevention (OJJDP)** identifies prevention as the critical first step to reducing serious and chronic juvenile delinquency, which includes crime, violence, and substance abuse among adolescents and young adults. OJJDP advocates a definition of "risk-focused prevention," which refers to prevention approaches that reduce risk and enhance protection:

> Prevention approaches attempt to interrupt the processes that produce problem behavior. During the past 30 years, research has identified precursors of juvenile delinquency and violence, called risk factors, as well as protective factors that buffer the effects of exposure to risks and inhibit the development of behavior problems even in the face of risk. (Office of Juvenile Justice and Delinquency Prevention, May 1995)

Risk and Protective Factors: Much of the research in the field of substance abuse has focused on risk and protective factors. In simple terms:

- **Risk factors** increase an individual, a group, or a community's vulnerability to substance abuse.
- **Protective factors** build a resiliency in the same individual, group, or community and increase the likelihood that they will successfully resist substance abuse and its related effects.

Researchers also have found that risk and protective factors extend across different areas (or domains) of a person's life. What happens in one domain affects events in the other domains. The following seven domains repeatedly appear in the research**: individual, peer, family, school, community, workplace, and society**. Appendix B contains more detailed explanations and specific examples of risk and protective factors associated with adolescent substance abuse.

The Institute of Medicine Definitions for Classifying Prevention Programs (IOM) divides programs and activities into three categories: **prevention, treatment, and maintenance**. The IOM and Substance Abuse and Mental Health Services Administration (SAMHSA) further divide the substance abuse prevention category into three classifications of interventions:

- **Universal programs** target either the general population or a segment of the population who share the same general risks in terms of probability of ATOD use.
- **Selective programs** target specific subgroups whose risk is significantly higher than the general population's.
- **Indicated** programs target high-risk individuals who are already substance users use or who exhibit behaviors or whose living circumstances put them at notably higher risk for ATOD use and/or addiction.

Appendix C contains more detailed explanations and examples of programs in each of the three categories.

The Center for Substance Abuse Prevention (CSAP) defines six categories of prevention strategies. Specific prevention programs can employ one or more of these strategies to reduce substance abuse problems before they start.

1. **Information dissemination** is designed to increase knowledge and alter attitudes about issues related to alcohol, tobacco, and other drug use and abuse. Examples: alcohol and drug information centers; newsletters and brochures; speaking engagements; health fairs; radio and TV public service announcements.

2. **Prevention education** provides instruction about alcohol and drug use, abuse and addiction, and teaches participants critical personal and social skills that promote health and well being among youths and help them avoid substance abuse. Examples: classroom-based instruction; training workshops.

3. **Alternatives** assume that youth who participate in drug-free activities will have important developmental needs met through these activities rather than through drug related activities. Examples: after-school educational and recreational activities; drop-in centers; after-prom parties; drug-free dances and parties.

4. **Problem identification and referral** involves recognizing youth who have already tried drugs or developed substance use problems and referring them for assessment, educational programs, and/or treatment. Examples: alcohol and drug hotlines; court diversion programs; the Student Assistance Program.[2]

5. **Community-based process** enhances community resource involvement in substance abuse prevention by building interagency coalitions and training community members and agencies in substance abuse education and prevention. Examples: public/private community planning groups; task forces; and action teams.

6. **Environmental approaches** attempt to promote policies that reduce risk factors and/or increase protective factors related to substance abuse. Examples: drug-free school zones; lobbying to increase taxes on alcohol/tobacco products; billboards/advertising; mass media campaign to decrease student binge drinking.

[2] Across the country, federal Drug-free Schools and Communities funds support local implementation of the Student Assistance Program, which involves identifying students who may be using drugs or alcohol, providing counseling for students who are using drugs or whose poor academic performance place them at risk for substance abuse, and working with parents and community groups to deal with substance abuse problems.

II. Alcohol, Tobacco, and Other Drug Use Among School-Age Youth[1]

Since 1992 the statewide Maryland Adolescent Survey and the National Monitoring the Future surveys have reported on alcohol, tobacco, and other drug (ATOD) use among school-age youth. What follows are some of the reports' key findings.

- The majority of young persons do not use alcohol, tobacco, and/or other drugs on a regular basis.

- The percentage of students who report consuming alcohol, smoking cigarettes, and/or taking other drugs increases with age.

- Alcohol is the substance most commonly used by school-age youth. Among Montgomery County Public Schools (MCPS) students, marijuana is the second most commonly used substance, with cigarettes coming in third.

- ATOD use among MCPS students, as among student state and nationwide, peaked in the mid-1990's. Between 1998 and 2001, alcohol and cigarette use declined significantly.

- During the past decade, the self-reported use of alcohol and tobacco by MCPS students has remained at or below the percentages reported State and nationwide. Over the same time period, the self-reported use of marijuana and other drugs by MCPS students has not consistently been above or below that reported elsewhere.

Substance Use in Montgomery County - 2001 Survey Data

The Maryland Department of Education regularly surveys 6th, 8th, 10th, and 12th graders throughout the State on their use of alcohol, tobacco, and other drugs. In the spring of 2001, 1,724 MCPS students in 6th, 8th, 10th, and 12th grades completed the MAS. Table 1 (page 10) summarizes the survey results, which are considered accurate + or – 2.5% based on a 95% confidence interval.[2] The data show that:

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[1] For purposes of including statistics on alcohol, tobacco, and other drug use by school age youth in the County, OLO chose to present data from the Maryland Adolescent Survey and the Monitoring the Future surveys because they are easy to understand, allow for comparisons of County data to State and nationwide data, and can be used to track trends in self-reported use. Examples of other data that are cited sometimes as indicators of substance use among youth are: emergency room episodes related to alcohol and drug use, alcohol-related traffic crashes involving persons under 21, and surveys of students' attitudes and beliefs about drugs. See Appendix D for data compiled by the University of Maryland Center for Substance Abuse Research.

[2] Appendix E contains the methodology chapter from the 2001 MAS report. Appendix F contains a September 2001 report issued by MCPS' Office of Shared Accountability that summarizes the 2001 Maryland Adolescent Survey results; the Technical Appendix (page 6) details the number of students surveyed in Montgomery County and explains the statistical significance of the results. Appendix G contains maps of 2001 survey results by county.

The majority of MCPS students do not use alcohol, tobacco, or other drugs on a regular basis. Although a considerable number of County youth report having consumed alcohol, smoked cigarettes, and/or taken other drugs, the data show that more than half are not using on a regular basis, i.e. within the past 30 days. This "good news" fact sometimes gets lost when the focus is on the changing percentages of students who are ATOD users.

Alcohol is the illegal substance most commonly used by County students. Of the MCPS 12th graders surveyed, 66% report having ever tried some form of alcohol; 44% drank during the last 30 days; and 28% had five or more servings of alcohol on the same occasion within the last 30 days. Beer, wine, or wine coolers are the most frequently used category of alcohol.

Marijuana is the second most commonly used substance by students in 8th ,10th, and 12th grades. 22% of 12th graders, 16% of 10th graders, and 7% of 8th graders report having used marijuana within the last 30 days. Substantially higher percentages of students report ever having used marijuana: 43% of 12th graders; 29% of 10th graders; and 12% of 8th graders.

Cigarettes are the third most used substance by students in 8th, 10th, and 12th grades. 21% of 12th graders, 11% of 10th graders, and 6% of 8th graders report smoking cigarettes within the past 30 days. As with other substances, the percentages of students who report ever having used cigarettes are substantially higher: 40% of 12th graders; 29% of 10th graders; and 17% of 8th graders.

Regular use of illegal substances other than alcohol, marijuana, and cigarettes remains relatively low. Table 1 (page 10) shows use percentages reported for other illegal substances. Of these substances, 12th graders were most likely to have tried designer drugs (MDMA or ecstasy, 9.9%), amphetamines (8.7%), and LSD (7.9%). However, among these substances, 12th grader use in the last 30 days is reported by only 1.6%, 3.2%, and 1.2% of the students respectively.

The percentages of students who report ATOD use rises rapidly with age. While only two percent of 6th graders report consuming alcohol within the past 30 days, the percentages increase to 15%, 27%, and 44% for 8th, 10th, and 12th graders respectively. A similar pattern, although at lower rates of use, is found with cigarettes and other drugs.

The largest single percent difference in ATOD use between grades occurs in the use of alcohol between 10th and 12th grade. While 27% of 10th graders report consuming alcohol within the past 30 days, 44% of MCPS 12th graders report using alcohol during the previous 30-day period. This is an increase of 17 percentage points.

Substance Use by MCPS Students Compared to Use State and Nationwide

Table 2 (page 11) compares Montgomery County (MCPS students) ATOD use data to State and nationwide data. Montgomery County and State data come from the 2001 Maryland Adolescent Survey. Nationwide data come from the 2000 *Monitoring the Future* survey.

The Maryland Department of Education designs the Maryland Adolescent Survey explicitly to parallel the annual *Monitoring the Future* (MTF) survey, which is conducted annually by the U.S. Department of Health and Human Services' National Institute on Drug Abuse. The 2000 MTF results are based on surveys completed by more than 45,000 students (8th, 10th, and 12th graders) across the United States.

Across age categories, the rates of use of alcohol and cigarettes reported by MCPS students are below the rates of use reported state and nationwide. Although the difference varies from less than one percent to more than 12 percent, the use of alcohol and cigarettes reported by MCPS students is lower than that reported across Maryland and across the country.

The largest percentage differences between MCPS and nationwide data are in the reported use of alcohol and cigarettes among 10th graders. Specifically, 27% of County 10th graders compared to 39% of 10th graders nationwide report consuming alcohol in the past 30 days. And 11% of County 10th graders compared to 21% of 10th graders nationwide report smoking cigarettes in the past 30 days.

The smallest percentage differences between County and nationwide data are in the reported use of marijuana and other drugs (other than alcohol and cigarettes) among 8th and 12th graders. Specifically, 25.9% of County 12th graders compared to 25.7% of 12th graders nationwide report consuming marijuana or other drugs in the past 30 days. Little difference also is seen in the use rates reported by County 8th graders (11.3%) vs. 8th graders nationwide (11.7%).

The Trends

Table 3 (page 12) summarizes ATOD use reported by youth in the County, State, and nationwide over time since 1994. Use of ATOD by youth across the Nation fluctuated during the 1990's with increases in the mid-1990's followed by declines in most categories since 1998. The trends in reported ATOD use among MCPS students show that:

Alcohol and Cigarette Use by MCPS students during the past decade is at or below the rates reported by students both State and nationwide. The fluctuations in reported alcohol and cigarette use in Montgomery County generally parallel changes reported elsewhere.

Between 1998 and 2001, the self-reported use of alcohol and cigarettes declined among all MCPS age groups surveyed. For example the percentages of MCPS 12th graders who report using alcohol in the past 30 days declined from 50% in 1998 to 44% in 2001; among MCPS 12th graders the percentages who report using cigarettes in the past 30 days declined from 30% in 1998 to 21% in 2001. (See Charts 1 and 2 on page 13.)

During the past decade MCPS students reported use of marijuana and other drugs (other than alcohol and tobacco) at rates sometimes above and sometimes below that reported by students State and nationwide. For example, 12th graders in the County have consistently reported rates of other drug use at rates at or above that reported nationwide; 8th graders in the County reported use rates significantly higher than those nationwide in 1994 (20% vs. 11%), but lower than nationwide rates in 1996, 1998, and 2001.

Comparisons of 2001 to 1998 results show little change in the use of other drugs. Self-reported use of marijuana and other drugs changed little between 1998 and 2001. For example, MCPS students reported similar rates of marijuana use in 1998 and 2001. The reported use of designer drugs by MCPS students was slightly higher but not statistically significant. (See Charts 1 and 2 on page 13.)

TABLE 1: 2001 MARYLAND ADOLESCENT SURVEY RESULTS FOR MONTGOMERY COUNTY[1]

Substance	6th Graders		8th Graders		10th Graders		12th Graders	
	Ever Used	Last 30 days	Ever Used	Last 30 days	Ever Used	Last 30 days	Ever Used	Last 30 days
Alcohol								
Any form of alcohol	6.3	2.3	30.2	15.3	49.9	26.8	66.2	43.8
Beer, wine, or wine coolers	5.5	2.3	28.5	14.3	48.8	24.7	63.7	39.5
Liquor (e.g., rum, whisky, vodka)	3.1	0.7	16.5	8.1	37.8	19.6	55.2	35.3
Five or more servings of alcohol on the same occasion	3.6	2.3	10.9	5.8	28.9	16.6	44.1	27.5
Tobacco								
Cigarettes	3.0	0.8	17.2	6.4	29.0	11.4	40.1	21.1
Smokeless tobacco	0.5	0.3	3.1	1.9	2.7	1.0	6.7	2.7
Marijuana and Other Drugs								
Marijuana	1.8	0.2	11.7	6.8	28.8	15.7	43.1	22.0
Designer drugs (MDMA, Ecstasy)	0.5	0.0	3.9	1.9	7.7	3.9	9.9	1.6
Amphetamines (uppers, bennies, speed, dexies)	0.2	0.0	4.8	1.8	4.9	3.3	8.7	3.2
LSD (acid, stickers)	0.3	0.3	3.7	2.4	2.4	1.6	7.9	1.2
Inhalants	2.0	0.8	6.7	2.7	2.9	1.1	3.1	0.4
Crack (rock)	0.5	0.5	2.7	1.2	1.1	0.8	1.1	0.0
Methamphetamines(meth, speed, crank, ice)	0.0	0.0	3.5	0.7	1.6	0.7	1.9	0.4
PCP (angel dust, love boat, green)	0.3	0.3	2.7	1.7	2.5	2.0	2.1	0.7
Heroin (smack)	0.5	0.5	1.9	1.4	0.5	0.2	0.7	0.0
Barbiturates and/or tranquilizers	0.3	0.3	1.2	0.7	2.3	1.0	0.7	0.3
Narcotics (codeine, percodan)	0.3	0.0	2.2	0.9	3.4	2.4	3.3	0.4
Other hallucinogens (mescaline)	0.3	0.3	3.2	2.2	3.8	2.8	6.2	1.9
Steroids for body building	1.0	0.5	2.6	1.4	0.8	0.5	1.7	1.3
Ritalin	1.1	0.0	2.1	0.7	3.9	2.0	3.7	1.2
Any drug other than alcohol or tobacco	5.6	1.3	20.1	11.3	35.1	19.8	50.3	25.9

[1] Source: Maryland Adolescent Survey (MAS) Report 2001. Local School System Findings, Maryland State Department of Education, September 2001. Montgomery County results are based upon surveys completed by 1,724 MCPS students in 6th, 8th, 10th, and 12th grades. Appendix E contains the methodology chapter from the 2001 MAS report; Appendix F contains a report from MCPS' Office of Shared Accountability that further details the survey design in Montgomery County and explains the statistical significance of the results.

TABLE 2: PERCENTAGES OF SELF-REPORTED SUBSTANCE USE AMONG STUDENTS IN THE LAST 30 DAYS MONTGOMERY COUNTY, MARYLAND AND NATIONAL DATA: 2001

Substance	Alcohol				Cigarettes				Marijuana and Other Drugs			
Grade	**6th**	**8th**	**10th**	**12th**	**6th**	**8th**	**10th**	**12th**	**6th**	**8th**	**10th**	**12th**
National**	N/A	21.5	39.0	49.8	N/A	12.2	21.3	29.5	N/A	11.7	22.7	25.7
Maryland*** (statewide)	6.3	22.8	35.9	47.5	2.5	10.6	16.6	25.5	4.5	15.2	24.3	28.2
Montgomery County***	2.3	15.3	26.8	43. 8	0.8	6.4	11.4	21.1	1.3	11.3	19.8	25.9

*"Other drugs" includes use of designer drugs, amphetamines, LSD, inhalants, crack, methamphetamines, PCP, heroin, barbiturates/tranquilizers, and narcotics, other hallucinogens (mescaline, 'shrooms), steroids for body building, and/or ritalin.
**Source: Results from the Monitoring the Future Survey, 2001.
*** Source: Results from the Maryland Adolescent Survey, 2001.

TABLE 3: PERCENTAGES OF SELF-REPORTED SUBSTANCE USE AMONG STUDENTS IN THE LAST 30 DAYS MONTGOMERY COUNTY, MARYLAND, AND NATIONAL DATA: 1994, 1996, 1998, AND 2001*

Substance	Alcohol				Cigarettes				Marijuana and Other Drugs*			
Grade	**6th**	**8th**	**10th**	**12th**	**6th**	**8th**	**10th**	**12th**	**6th**	**8th**	**10th**	**12th**
1994												
National	**N/A**	25.5	39.2	50.1	**N/A**	18.6	25.4	31.2	**N/A**	10.9	18.5	21.9
State	10.4	31.0	45.0	53.3	5.4	20.8	26.7	29.9	5.9	21.4	27.4	29.9
Mont. Co.	6.7	28.1	37.7	51.5	1.3	19.3	23.2	29.8	2.3	20.0	22.5	29.5
1996												
National	**N/A**	26.2	40.4	50.8	**N/A**	21.0	30.4	34.0	**N/A**	14.6	23.2	24.6
State	7.9	27.1	43.7	52.4	4.6	17.0	25.1	32.0	4.0	16.3	26.4	31.2
Mont. Co.	6.6	21.7	35.1	53.2	1.8	14.6	19.7	33.6	3.1	10.0	17.6	32.6
1998												
National	**N/A**	23.0	38.8	52.0	**N/A**	19.1	27.6	35.1	**N/A**	12.1	21.5	25.6
State	9.1	26.6	42.9	48.4	4.2	14.8	23.9	28.6	5.2	15.0	26.6	28.1
Mont. Co.	4.2	18.4	38.7	50.4	2.2	11.5	22.5	27.7	3.8	10.5	22.2	25.8
2001												
National	**N/A**	21.5	39.0	49.8	**N/A**	12.2	21.3	29.5	**N/A**	11.7	22.7	25.7
State	6.3	22.8	35.9	47.5	2.5	10.6	16.6	25.5	4.5	15.2	24.3	28.2
Mont. Co.	2.3	15.3	26.8	43.8	0.8	6.4	11.4	21.1	1.3	11.3	19.8	25.9

*Montgomery County and Maryland statewide data are from the Maryland Adolescent Survey reports, 1994, 1996, 1998, and 2001. National data are from Monitoring the Future survey results, 1994, 1996, 1998, and 2001. The MTF survey does not survey 6th graders.

**The list of "other drugs" includes use of designer drugs, amphetamines, LSD, inhalants, crack, methamphetamines, PCP, heroin, barbiturates/tranquilizers, and narcotics, other hallucinogens (mescaline, 'shrooms), steroids for body building, and/or ritalin.

CHART 1

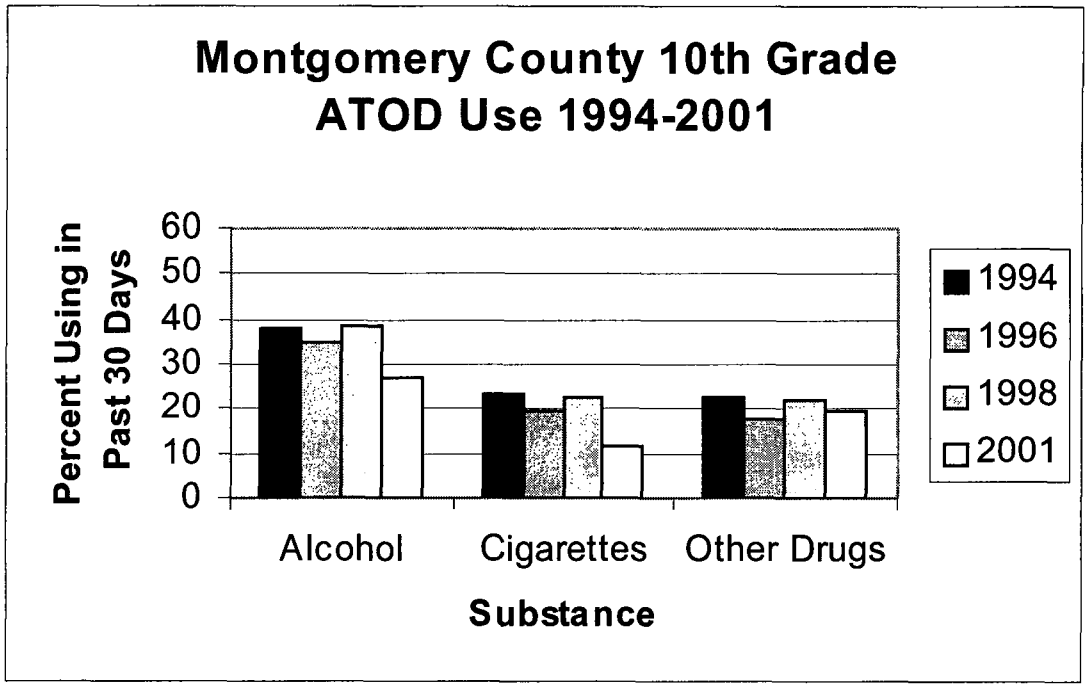
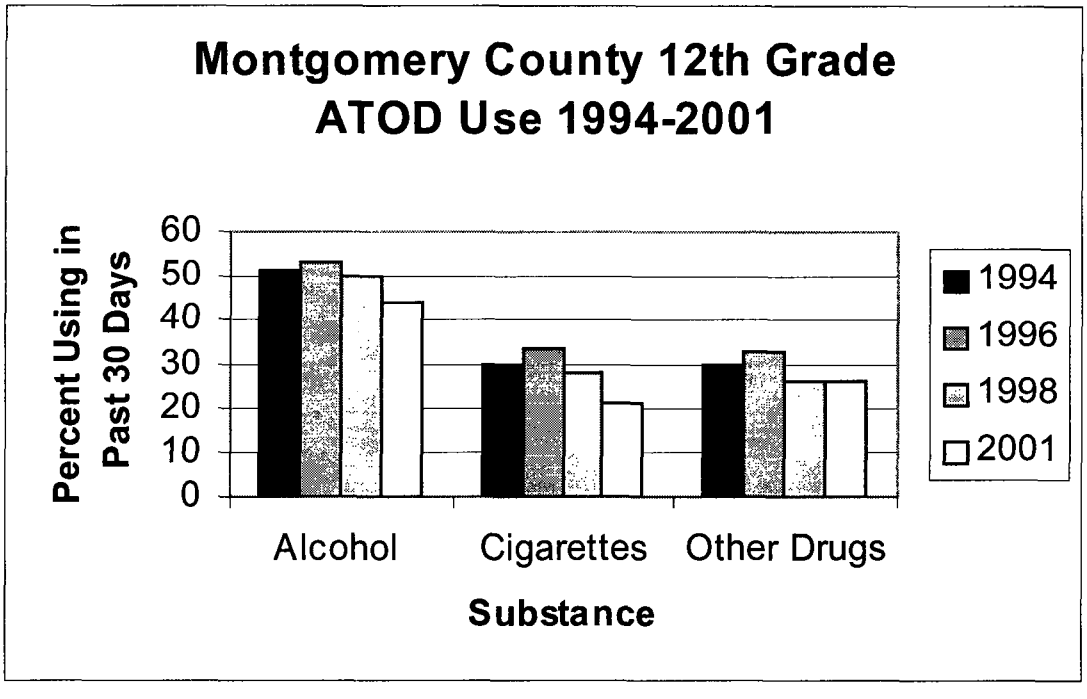


CHART 2



III. Substance Abuse Prevention: What Works?

A considerable volume of research exists about "what works" in the field of alcohol, tobacco, and other drug (ATOD) prevention. The research base, developed over the past 25 years, is broad and complex. Studies on the effectiveness of prevention are often linked to research on education, criminal justice, and/or family and social systems.

As a whole, the body of substance abuse prevention research constitutes a systematic and objective examination of the efficacy and effectiveness of programs and policies. The studies include a mix of observational and controlled experimental and quasi-experimental research designs, and many meet the high standards for what the academic world calls "rigorous" research.

Evaluations of prevention programs designed to reduce or eliminate alcohol, tobacco, and/or other drug use by youth typically measure the following outcomes:

- Frequency of ATOD use;
- Age of first ATOD use;
- Youth perceptions of ATOD use; and/or
- Related risk or protective factors.

Practitioners across the country (including those here in Montgomery County) are eager to implement prevention programs and activities that are supported by science-based research. In recent years, practitioners have gained greater access to prevention research findings as federal agencies have improved their dissemination of information. The rest of the chapter consists of two parts:

Part A, Lessons from the Research, summarizes themes from the emerging science of substance abuse prevention.

Part B, Resources, presents information on the federal government's efforts to disseminate information about effective substance abuse prevention programs.

A. Lessons from the Research

Central to the public sector's substance abuse prevention strategy has long been a focus on children and youth. The research clearly shows that early use of alcohol and other drugs is linked to later substance abuse, and early involvement with any drug is a risk factor for later drug use and criminal activity.

A multitude of prevention programs designed to reduce or eliminate young people's use and abuse of alcohol, tobacco, and other drugs have been evaluated during the past 20 years. Consistent themes reported in the research include that:

- No one best prevention program and no one program or approach will stop all drug use.
- While many effective research-based programs exist, the best approach for any particular population requires knowledge of the risk and protective factors in the target population and then selecting the best intervention for that population.
- The best approach to prevention begins early to reduce in youth emerging behavioral and emotional problems.
- The most effective prevention programs are not necessarily the most highly marketed.
- Increased knowledge and changed attitudes towards alcohol and drugs do not necessarily indicate eventual behavioral changes.

What Scientists Know about Prevention

Much of the research in the field of substance abuse has focused on risk and protective factors. In simple terms, **risk factors** increase an individual, a group, or a community's vulnerability to substance abuse; **protective factors** build resiliency in the same individual, group, or community and increase the likelihood that they will successfully resist substance abuse and its related effects.

Researchers have determined that risk and protective factors are interrelated. Both must be well understood for an effective substance abuse prevention program. Researchers also have found that risk and protective factors extend across different areas (or domains) of a person's life. The seven domains repeatedly discussed in the research are: individual, peer, family, school, community, workplace, and society. What happens in one domain affects events in the other domains.

Prevention programs can achieve positive outcomes - to delay, reduce, or prevent altogether substance abuse—in one or more than one domain. The chances of overall positive outcomes thereby increases and the benefits are extended. This finding has led researchers to recommend multiple interventions across multiple domains.

Appendix H contains a document published by the federal Substance Abuse and Mental Health Services Administration (SAMHSA, 2001), *"What Scientists Know about Prevention."* It summarizes what is known about the relationship between risk and protective factors for substance abuse and each of the seven life domains. Examples of these findings are that:

- Youth who believe that cigarettes or drugs will cause them physical harm are less likely to smoke or use drugs; young people tend to be more concerned about the immediate effects of substance use than about the long-term effects.

- Among boys especially, aggressive and disruptive classroom behavior predicts substance abuse.

- Parental monitoring and supervision of children's activities protect against substance use.

- Parental substance abuse disorders predict substance abuse in their children during adolescence.

- Sustained involvement in structured peer activities, including extracurricular programs, is linked with low levels of drug use.

- Peer substance use is among the strongest predictors of an individual's substance use, although peer influences are weaker for Black youth than for Latino or White youth.

- Communities lacking resources are vulnerable to high rates of adolescent substance abuse.

- The ability to purchase alcohol is related to its consumption and related problem behaviors.

Highlights of Research Findings for Specific Strategies

The research identifies a wide-range of promising approaches designed to reach young people in different parts of their lives. This section starts with a discussion of the general advantages and disadvantages of **universal** vs. **selective** vs. **indicated** programs.[1] It is followed by a summary of research findings on the effectiveness of specific prevention strategies: teaching prevention in schools; activities outside of school; student assistance programs, community coalitions, family prevention programs, and environmental strategies.

[1] In sum, universal programs target a general population; selective programs target specific subgroups whose risk is significantly higher than the general population's; and indicated programs target high-risk individuals who have already experimented with ATOD use. For a more detailed explanation of the three categories, see Appendix C.

Advantages and Disadvantages of Universal vs. Selective vs. Indicated Programs

A major advantage of **universal prevention programs** is that they are less expensive per participant. This is because they are, in general, of shorter length and do not require special recruitment efforts. Universal prevention programs most often take place in school settings, which means that they affect all students regardless of risk status. Since a smaller percentage of participants have "room for improvement" the measured effectiveness of universal programs is typically smaller than for selective or indicated programs.

The major disadvantages of classroom-based universal prevention programs are that they frequently do not contain content tailored to the subset of higher risk students. In addition, some of the most-at-risk students may not fully participate due to truancy and frequent school absences. Universal alternative activities (e.g., after-school educational or recreational programs) face a similar dilemma: some of the youth who would most benefit from participation in structured, supervised, and drug-free activities do not enroll.

By definition, **selective prevention programs** are offered to at-risk groups of youth and families. Examples are programs designed for children of alcoholics, children in poverty, or children of recently immigrated families. Although more expensive per participant than universal programs, some see selective programs as "more efficient" because they focus resources where the need has been identified. Research has found that to be effective selective programs need to be longer (the advice is 45 hours, at minimum) and more intensive than universal programs, and designed explicitly for their target audience.

The cited advantages of **indicated prevention programs** parallel those of selective programs, that is, they provide a way to target limited prevention resources to populations in need. The disadvantages of indicated programs are primarily the challenges of hiring staff with the skills needed to deliver effective programs to youth already exhibiting substance use behaviors such as conduct disorder, aggression, anxiety, and lack of social and life skills. According to some research, offering indicated programs without staff sufficiently trained in managing group behaviors and norms can actually result in increased drug use among participants.

Teaching Prevention in Schools

Much research has been conducted on what makes school-based prevention programs effective. It is clear that prevention efforts should begin early and continue through adolescence when young people face more immediate pressures to drink, smoke, and use other drugs. Without reinforcement or "booster" sessions, the impact of prevention programs on actual drug use behavior is greatly reduced.

Substantial evidence indicates that providing young people with accurate information about alcohol, tobacco, and drugs increases knowledge of adverse drug effects, but alone does not have an impact on drug use behavior. Some evidence shows that providing information about the dangers and risks may even be counterproductive with students who seek adventure. In addition, attempts to generate fear by exaggerating or dramatizing the risks associated with substance use is not effective, especially if the information shared contradicts the students' own experience.

According to *Making the Grade: A Guide to School Drug Prevention Programs,*[2] successful school-based drug prevention programs must go beyond the knowledge-only approach and do the following:

- Help students recognize internal pressures such as anxiety and stress, and external pressures such as peer attitudes and advertising, that influence their use alcohol, tobacco, and other drugs.

- Develop students' personal, social, and refusal skills to resist these pressures.

- Teach that using alcohol, tobacco, and other drugs is not the norm among teenagers, even if students believe that "everyone is doing it."

- Provide developmentally appropriate material and activities, including information about the short-term effects and long-term consequences of using alcohol, tobacco, and other drugs.

- Use interactive teaching techniques, such as role playing, discussions, brainstorming, and cooperative learning,

- Cover necessary prevention elements in at least ten sessions a year (with a minimum of three to five booster sessions in two succeeding years)

- Actively involve the family and the community.

- Include teacher training and support with material that is easy for teachers to implement and culturally relevant for students.

[2] Cited in *Promising Strategies to Reduce Substance Abuse*, Office of Justice Programs, U.S. Department of Justice, 2000.

Appendix I contains summary descriptions of three school-based prevention programs that have demonstrated positive results: Life Skills Training; Project ALERT; and Project Towards No Tobacco. In sum:

IV.

V. Life Skills Training:

The Life Skills Training (LST) program has consistently been shown to significantly reduce ATOD use. LST has curricula for elementary school students (8-11 years old) and middle school students (11-14 years old) that are delivered in a series of classroom sessions over three years. Specific outcomes for LST participants compared to control groups have included: reduced alcohol use by 54%; reduced heavy drinking by 73%; reduced marijuana use by 71%; and reduced initiation of cigarette smoking by 75%.

VI. Project ALERT

Project ALERT has demonstrated effectiveness in decreasing pro-drug attitudes and beliefs and reducing use of marijuana and cigarettes. Marijuana initiation rates among ALERT students, for example, declined by 30%, and cigarette use dropped 20-25%. (Four years ago, MCPS selected Project ALERT to include in the County's middle school health curriculum.)

VII. Project Towards No Tobacco Use (TNT)

Relative to students in control groups, students in Project TNT have shown reduced initiation of cigarettes by an average of 26%; reduced initiation of smokeless tobacco use by an average of 30%; and reduced weekly or more frequent cigarette smoking by about 60%. (Four years ago, MCPS also selected Project TNT to include the County's middle school health curriculum.)

Research on the Drug Abuse Resistance Education (DARE) Program

DARE, the most widely implemented school-based drug prevention program in the United States, is currently provided to 5th and 6th graders in approximately 80% of the nation's school districts. Law enforcement officers teach the core DARE program. (In Montgomery County, DARE is provided to 5th graders in most public and some private schools.[3])

Extensive research documents immediate and short-term (up to two years) positive outcomes of DARE in terms of students' resistance skills and attitudes towards drugs. In addition, DARE provides an opportunity for positive interactions among students, law enforcement officers, teachers, and parents. Surveys of DARE participants consistently report that students completing the program have positive things to say about it. In addition, many parents and teachers indicate strong support for DARE.

[3] For more details about the DARE program in Montgomery County, see Appendix A, ©A-78.

However, the research on the longer-term effects of DARE has found that children who participate in DARE are as likely to use drugs as those who do not participate. A 2000 report from the National Academy of Sciences (*Preventing Juvenile Crime*, National Academy of Sciences, 2000) summarizes the research on DARE as follows: "None of the methodologically rigorous evaluations have found any reduction in drug use among students who have been through the DARE program." (Clayton et al., 1996; Ennett et al., 1997; Rosenbaum et al., 1994; Sigler and Talley, 1995 cited in National Academy of Sciences, 2000).

Writing in 2001, the Surgeon General of the United States cites DARE as the one school-based prevention program that meets the criteria for "Does Not Work." In his report, the Surgeon General acknowledges that the popularity of DARE persists despite numerous well-designed evaluations and meta-analyses that consistently show little or no deterrent effects on substance use. (United States Office of Surgeon General, January 2001)

Over the years, DARE's curriculum has been revised several times. A new DARE program is in the process of being developed and tested with the support of a $13.7 million grant from the Robert Wood Johnson Foundation. Reportedly, DARE's focus will shift from 5th grade to 7th grade students, and add a booster program in 9th grade. In addition, the new program will be more interactive, with students doing more role-playing on how to make decisions.

In sum, with the DARE curriculum continuing to change, determining its bottom-line effectiveness is difficult. For more on the DARE debate see Appendix J which includes two responses to the question "Does the DARE program work?" posted on the American Federation for Teachers website; a 1999 article from the Journal of Consulting and Clinical Psychology, *Project DARE: No Effects at 10-Year Follow-up*; and an excerpt from the DARE website that responds to the research findings.

Student Assistance Programs

Student Assistance Programs are school-based interventions that provide students with support for a variety of problems, such as depression, behavioral problems and drug and alcohol abuse. Student Assistance Program models differ slightly, but most include early identification of student problems, assessment of a student's needs, counseling and referral to outside agencies or treatment facilities.

Student Assistance Programs are one of the most common intervention programs in schools across the country, primarily because they are required and funded through federal Safe and Drug Free Schools and Communities Act funds (SDFS). In Montgomery County, the Student Assistance Program is one the largest programs within the Safe and Drug Free Schools Project.[4]

[4] For more about the Student Assistance Program in Montgomery County, see Appendix A, ©A-31.

There is very little research on the effectiveness of Student Assistance Programs, but a few recent studies have found that fewer students reported using drugs or alcohol after participating in a Student Assistance Program. However, because Student Assistance Programs do vary, it is difficult to conduct effective nation-wide-evaluations. (Sherman et al, 2001; The National Center on Addiction and Substance Abuse at Columbia University, September 2001)

Activities Outside of School

Many jurisdictions across the country (including Montgomery County) offer structured, supervised, and safe activities for youth outside of school hours—supervised recreation, mentoring, and educational opportunities—in the hope that involving youth in such activities will prevent, reduce, or delay the onset of alcohol, tobacco, and drug use. After-school hours are known as "high-risk" periods for young people. For example, approximately one-third of all violent juvenile crime occurs between 3 PM to 7 PM.

The Center for Substance Abuse and Prevention's *Technical Report 13: A Review of Alternative Activities and Alternative Programs in Youth-Oriented Prevention* (CSAP, 1996), found that alternative activities are likely to include one or more of the following elements:

- Promotion of skills, knowledge, and/or attitudes that support youth in refraining from future substance abuse;
- Occupation of free time that might otherwise be idle or unstructured;
- Community services that provides meaningful involvement in socially responsible activities;
- Opportunities to interact in positive ways with peers; and
- Adult supervision or development of positive relationship with adults.

Most alternative activity programs do not directly include prevention education.

Among the research literature, few evaluations of alternative activity programs exist. Those that do provide little evidence that alternative activities *alone* prevent or reduce alcohol and other drug use. There also is little hard evidence to indicate what types of alternative programs are likely to be effective with what types of youth. As the Center for Substance Abuse and Prevention writes:

> Most alternatives programs are developed and implemented because they sound like a good idea, not because there is strong research support for a particular approach or even for alternatives in general." (CSAP, *Technical Report 13*, 1996, p. 19)

Nonetheless, the general consensus in the research appears to be that when used in conjunction with other prevention strategies, alternative activities can play an important role in reducing alcohol and other drug use. In addition, alternative programming appears to be most effective among those youth at greatest risk for substance abuse and related problems, and more intensive programs (i.e., greater numbers of hours) seem to be most effective. A number of evaluations of individual after school recreation programs have documented improvements in protective factors for program participants.[5]

The 1996 CSAP report on alternative activities concludes the following:

> Even in the absence of rigorous research, most people would probably agree that youth are likely to develop substance abuse problems (as well as problems of every other sort) when they are surrounded by caring adults, given loving supervision, and offered age-appropriate challenges and opportunities to grow. Similarly, children and youth whose lives are enriched with a variety of interesting opportunities to learn and develop skills are likely to be better off than those for whom few opportunities exist. In an ideal world, adult contact and opportunities for development would occur as a natural part of daily life for all children. Since, for many children, these advantages are not readily available, more formal programs are created.

Worth particular mention is the reported success of mentoring programs in reducing drug use. In response to positive results demonstrated by Big Brothers/Big Sisters of America, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) developed the Juvenile Mentoring Project to identify elements of effective mentoring programs. The elements identified included, for example:

- Creating collaboration between community-based providers and local education agencies to improve school performance and reduce school drop-out rates and juvenile delinquency;
- Performing thorough background checks for all volunteer mentors; and
- Assessing youth participants carefully in order to make appropriate matches.

Community Coalitions

During the past decade, community coalitions aimed at addressing the problems of substance abuse and related crime came together in many jurisdictions across the country. Supported by foundations and federal government grants, the various coalitions bring together different stakeholders (e.g., government officials, residents, business leaders, services providers, law enforcement officers) to address one or more issues related to substance abuse.

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[5] *Technical Report 13, A Review of Alternative Activities*, CSAP, 1996; *Preventing Crime: What Works, What Doesn't, What's Promising,* National Institute of Justice, 1999, and *Re-Examining the Role of Recreation and Parks in After-School Programs*, Witt, July 2001 re-print. (Copy of Witt article in Appendix K)

Financial support for community coalitions has come from the Center for Substance Abuse Prevention's Community Partnership program, the Office of Juvenile Justice and Delinquency Programs Drug-Free Communities Support Program, and the Robert Wood Johnson Foundation. OJJDP's Combating Underage Drinking Program has specifically supported coalitions focused on curbing youth alcohol use. Another DOJ program, Weed and Seed, has supported local efforts to control, reduce, and prevent violent crime and drug abuse.[6]

While recognizing the interest and funding in the area of community partnerships, little research exists to demonstrate the effectiveness of this approach. According to a literature review of drug abuse prevention programs prepared under the auspices of the National Institute of Drug Abuse:

> Although logically appealing, there are few randomized control trials to demonstrate clearly the effectiveness of community partnerships. One of the problems is that it is almost impossible to conduct true randomized control trials with communities. (Kumpfer, NIDA Resource Center)

In 1999, the Center for Substance Abuse Prevention conducted a study of 48 community partnerships across the county. The study concluded that community partnerships can be effective in decreasing drug and alcohol use among males, and that community partnerships can play a key role in generating community involvement. The study identified elements of what the agency deems "successful" coalitions. Although not based on scientific research, these include:

- Understanding the community's needs and resources;
- A widely shared and comprehensive vision;
- A clear and focused strategic plan;
- Diverse membership (including key community leaders and government officials)
- Strong leadership and committed partners;
- Diversified funding; and
- A well managed staffing structure.

Family Prevention Programs

The research evidences that strong family protective factors (e.g., close parent-child relationships, positive discipline methods, effective supervision of children's activities) can inhibit or decrease substance abuse by adolescents. Similarly, family risk factors (e.g., parental neglect, substance abuse by parents and/or siblings, exposure to violence) can increase the probability that an adolescent will abuse drugs and alcohol.

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[6] Montgomery County's Drawing the Line on Underage Alcohol Use (DTL) was established in the early 1990's as a public-private coalition to address the issue of underage drinking. For more on DTL, see Appendix A, ©A-54.

For these reasons, some prevention programs focus on increasing family protective factors through teaching parenting skills, and reducing family risk factors through addressing parental substance abuse, domestic violence and/or child abuse.

Family prevention programs may be universal, selective or indicated depending on the audience they are targeting. For example, a universal family prevention program may seek to improve parents' overall child rearing skills, and parent-child bonding in weekly sessions, while a selective program may target families where one or both parents are substance abusers. These programs' goals are to help the parents improve their parenting skills, reduce the parents' use of drugs, and as a result, reduce their children's risk factors. (Bry, et al, 1998)

The National Institute on Drug Abuse (NIDA) recommends that family-based prevention programs incorporate the following principles:

- Reach families of children at each stage of development;
- Train parents in behavioral skills to reduce conduct problems in children, improve parent-child relationships, provide consistent discipline and rulemaking, and monitor children's activities during adolescence;
- Include an education component for parents with drug information for them and their children;
- Direct services to families with children in kindergarten through 12^{th} grade to enhance protective factors; and
- Provide access to counseling services to families at risk.

A number of evaluations of family prevention programs show these type of programs can be effective in increasing family functioning, which in turn decreases substance abuse among adolescents. Literature from the Center for Substance Abuse Prevention (CSAP) describes two universal family prevention programs (The Preparing for the Drug-Free Years Program and Iowa Strengthening Families Program) that were found to improve the participating parents' child management skills and parent-child relations.

The evaluation of the Strengthening Families Program also showed improved adolescent resistance to peer pressure, reduced affiliation with anti-social peers and reduced levels of problem behaviors in a one year follow-up. The authors of these evaluations determined from their research that the most effective ways of recruiting parental participation included practical recruitment practices, retention strategies, flexibility and multiple incentives. (Office of Justice Programs, September 2000, and National Institute on Drug Abuse, 1997)

Environmental Strategies

Environmental strategies aim to reduce the physical availability of alcohol and tobacco to minors and increase adults' and retail establishments' awareness of the legal and social risks of providing alcohol and tobacco to minors through law and policy changes. These strategies seek to create changes in a community, rather than just in individuals' behavior.

Examples of environmental strategies are:

- Increasing taxes on alcohol and tobacco;
- Sanctions against establishments that serve alcoholic beverages or sell tobacco products to minors;
- Mandating the training of alcohol beverage servers;
- Restricting the number and location of alcohol outlets;
- Requiring beer key registration; and
- Restricting alcohol in public places.

Empirical research shows that some environmental strategies can decrease the overall consumption of alcohol and are an effective countermeasure to problems associated with drinking. Numerous studies show that increases in alcohol taxes and/or increases in the price of alcoholic beverages reduce alcohol purchases, especially by youth. Other studies have specifically shown when price of alcohol rises, consumption by youth decreases. The same relationship has been shown to exist with increased price and decreased use of tobacco. (Chaloupka, et al 1994, Grossman, 1998, and Toomey and Wagenaar, 1999 all cited in Wagenaar, 2000)

Office of National Drug Policy's 15 Principles for Substance Abuse Prevention

Asked to develop a set of research-based principles upon which to base prevention programming, the ONDCP drew upon literature reviews and guidance supported by the federal departments of Education, Justice, and Health and Human Services. From these, ONDCP adopted the following 15 "evidence-based principles for substance abuse prevention."

ONDCP's Principles for Drug Abuse Prevention

Address appropriate risk and protective factors for substance abuse in a defined population

1. Define a population. Age, sex, race, geography, and institution can define a population.
2. Assess levels of risk, protections, and substance abuse for that population. Substance abuse can involve marijuana, cocaine, inhalants, methamphetamine, alcohol, and tobacco, as well as other psychoactive substances.
3. Prevention programs and policies should focus on all levels of risk, but special attention must be given to the most important risk factors. Population assessment can help sharpen the focus of prevention.

Use approaches that have been shown to be effective.

4. Reduce the availability of illicit drugs, and of alcohol and tobacco for the under-aged.
5. Strengthen anti-drug use attitudes and norms by sharing accurate information about substance abuse, encouraging drug-free activities, and enforcing laws and policies related to illicit substances.
6. Teach life skills and drug refusal techniques, using interactive techniques that focus on critical thinking, communication, and social competency.
7. Strengthen family skills by setting rules, clarifying expectations, monitoring behavior, communicating regularly, providing social support, and modeling positive behaviors.
8. Strengthen social bonding and caring relationships with people holding strong standards against substance abuse in families, schools, peer groups, mentoring programs, religious and spiritual contexts, and structured recreational activities.
9. Ensure that prevention interventions are acceptable to and appropriate for the needs and motivations of the populations and cultures being addressed.

Intervene early at important stages and transitions.

10. Intervene early and at development stages and life transitions that predict later substance abuse.
11. Reinforce interventions over time; repeated exposure to scientifically accurate and age appropriate anti-drug use messages can ensure that skills, norms, expectations, and behaviors learned earlier are reinforced over time.

Intervene in appropriate settings and domains.

12. Intervene in settings and domains that most affect risk and protection for substance abuse, including homes, social services, schools, peer groups, workplaces, recreational settings, religious and spiritual settings, and communities.

Manage programs effectively.

13. Implementation of prevention programs, policies, and message for different parts of the community should be consistent, compatible, and appropriate.
14. To ensure that prevention programs and messages are continually delivered as intended, training should be provided regularly to staff and volunteers.
15. To verify that goals and objectives are being achieved, program monitoring and evaluation should be a regular part of program implementation. When goals are not reached, adjustments should be made to increase effectiveness.

B. Resources

In recent years practitioners have gained opportunities to access prevention research findings. A number of federal agencies actively disseminate information on science-based prevention and provide technical assistance to encourage the implementation of programs with demonstrated effectiveness. Described below are the efforts of four federal agencies: Center for Substance Abuse Prevention; National Institute on Drug Abuse; Office of Juvenile Justice and Delinquency Prevention; and U.S. Department of Education.[7]

THE CENTER FOR SUBSTANCE ABUSE PREVENTION: NATIONAL REGISTRY OF EFFECTIVE PREVENTION PROGRAMS (NREPP)

In May 2000, the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Prevention (CSAP) launched the National Registry of Effective Prevention Programs (NREPP). The NREPP is an on-line national system with the stated intent of identifying and providing information and technical assistance about effective alcohol, tobacco, and other drug abuse prevention programs and policies.

CSAP invites practitioners in the field to submit their programs for review and possible inclusion on the NREPP. Programs submitted to CSAP are reviewed and rated by teams of scientists. CSAP classifies prevention programs, practices, and policies based upon the degree to which there is "scientific evidence of its effectiveness."

CSAP defines a scientifically defensible prevention strategy as an approach that is developed and evaluated using scientific methods. This means that:

- The strategy is grounded in a clear theoretical foundation;
- The strategy is carefully implemented, and evaluated;
- The evaluation findings are subjected to critical review by other researchers; and
- The strategy has been replicated in a variety of settings.

[7] Appendix L lists the different federal agencies involved with substance abuse prevention and briefly describes their respective roles.

The NREPP posts information about programs in three different categories: effective programs, model programs, and promising programs, which are defined as follows:

Effective programs produce a consistent positive pattern of results. Only those programs that positively affect the majority of intended recipients or targets are considered effective. These programs must score at least a 4.0 on a 5-point scale on parameters of integrity and utility. (Table 4 (page 29) explains the five rating categories.)

Model programs are effective programs whose developers have agreed to participate in CSAP's efforts and to provide training and technical assistance to practitioners who wish to adopt their programs. That help is essential to the careful implementation of the program, and maximizes the probability for repeated effectiveness.

Promising programs provide useful and scientifically defensible information about what works in prevention, but as yet have insufficient scientific support to attain the standards necessary for Effective program status. With review of additional documentation regarding program effectiveness, Promising programs may be elevated to Effective status if they score at least 3.33 on a 5-point scale that measures integrity and utility. CSAP provides feedback and resources and offers technical assistance to guide promising programs to advance their evaluations and status.

In addition to the National Registry, CSAP produces a "Series of Knowledge Tools." These publications articulate CSAP's policy direction and guidance to practitioners in the field on prevention programs known to be effective in creating positive change. Recent documents in this series include:

- *2001 Annual Report of Science-Based Prevention Programs* summarizes research findings on science-based prevention programs contained in the NREPP, and lists elements of model programs.

- *Prevention Works! A Practitioner's Guide to Achieving Outcomes* provides guidance to practitioners about structuring program evaluations and working with an evaluator.

- *Finding the Balance: Program Fidelity and Adaptation in Substance Abuse Prevention, A State of the Art Review* surveys 125 published and unpublished studies related to the "fidelity" and "adaptation" of prevention program implementation.

Note: Program "fidelity" refers to the degree to which a promising, effective, or model program matches its actual local implementation. This concept is also called program "adherence" or "integrity." Program "adaptation" refers to the deliberate or accidental modification of a program model, such as deletion or addition of program components or changes in the target population for which the program was designed.

TABLE 4
CENTER FOR SUBSTANCE ABUSE PREVENTION
RANKING OF EFFECTIVENESS

CSAP ranks programs according to the following hierarchy of effectiveness that ranks strategies 1, 2, 3,4 or 5 based upon the amount and quality of the evidence of their effectiveness.

Level of Effectiveness Rating	Summary Description of Effectiveness Data
1	Anecdotal evidence of positive results in the form of participant testimonials, media coverage; little or no systematic evaluation or empirical support. Level 1 programs are not considered research-based.
2	Positive outcomes have been documented in written form, e.g., conference or workshop report, internal report, published in refereed or non-refereed publications. Level 2 programs require some type of evaluation using methods such as pre/post design, comparison of participants' outcome norms to local or state averages, or qualitative date such as reports of client satisfaction.
3	Positive results of the program in a single population (or single setting) evaluation have been published in at least one scientific, peer reviewed, academic journal. The evaluation design must have included a pre and posttest with either a comparison or control group to assess impact, and must show some overall positive results.
4	Positive outcomes of the program have been identified as the result of either a meta-analysis[8] and/or expert review by a professional prevention organization or groups of prevention "experts" who review and rate programs for effectiveness. Results of such multiple analyses are typically published in a referred publication, dissertation, and/or evaluation report.
5	Positive outcomes of the program have been successfully replicated in several settings, preferably across multiple target populations with consideration for age, gender, race/ethnicity, and geographic context. The program must have been evaluated in its different settings using a pre and post test to show positive results, and positive results must be published in more than one scientific, peer reviewed, academic journal.

[8] **Meta-analysis** is a technically sound method of combining results from numerous studies. Meta-analysis of substance abuse prevention research synthesizes results from medical, psychiatric, and behavioral research literature.

THE NATIONAL INSTITUTE ON DRUG ABUSE (NIDA)

In 1997, NIDA published *Preventing Drug Use Among Children and Adolescents, A Research Based Guide.* This document provides an overview of the basic principles derived from NIDA's prevention research. It also identifies 10 programs studied and tested over a reasonable period of time and found to give positive results.

Since that time, NIDA has continued to identify and disseminate information about "exemplary programs" selected by a 15-member panel that base their choices on program effectiveness and quality. Relevant measures of success include reducing substance use and making schools safe, disciplined, and drug free. Measures of program quality include a program's ability to change behavior and/or risk and protective factors.

NIDA posts its findings on its *PreventionNet* website. *PreventionNet* also provides information about university-based prevention research centers (located at Cornell University Medical College, Pennsylvania State University, University of Kentucky, and University of Pittsburgh) that are funded currently by NIDA.

OFFICE OF JUVENILE JUSTICE AND DELINQUENCY PREVENTION (OJJDP): BLUEPRINTS

In 1996, the Center for the Study and Prevention of Violence (CSPV) at the University of Colorado initiated a project to identify and replicate violence prevention programs found effective in reducing adolescent violent crime, aggression, delinquency, and substance abuse.

The project, "Blueprints for Violence Prevention," identified 11 prevention and intervention programs that meet a strict scientific standard of effectiveness and rated another 19 programs as "promising." The Center reports that it has since reviewed more than 500 programs and continues to look for programs that meet its selection criteria.

The evaluation standards for substance abuse prevention effectiveness included reductions in the onset of drug use compared to control groups and pre vs. post reductions in drug use. The evaluations also looked at the extent to which short-term positive effects were sustained once participants left the program.

OJJDP funded a national dissemination effort for the Blueprint programs, which included technical assistance and monitoring components. With technical assistance from CSPV, 42 sites currently are implementing two-year Blueprint programs.

OJJDP also funded a broader dissemination of the drug prevention Blueprints program called Life Skills Training. For three years (through the end of the current 2001-2002 school year) CSPV is providing training and assistance to 142 schools implementing the LST program. An additional 145 schools will receive training and assistance until the end of the 2002-2003 school year.

U.S. Department of Education; Safe, Disciplined, and Drug Free Schools Expert Panel

The U.S. Department of Education Safe and Drug-Free Schools Program, as part of an ongoing process in cooperation with the Office of Educational Research and Improvement, also identifies effective programs. To that end they established the Drug Free Schools Expert Panel (SDDFS), a 15-member panel of researchers, program developers, education practitioners, along with representatives from state and local education agencies, businesses, medical, and legal communities.

The panel oversees a process for identifying and designating promising and exemplary school-based programs that promote safe, disciplined, and drug-free schools. The Department of Education disseminates information about programs it designated as promising or exemplary, and encourages their use in new sites.

In 2001, the Department and SDDFS identified nine exemplary and 33 promising programs. The Panel's criteria for evaluation included:

Evidence of Efficacy - that the program reports relevant evidence of efficacy/effectiveness based on a methodologically sound evaluation. Examples of relevant outcomes are factors related to making schools safe, disciplined, and drug free; reducing substance use, violence, and other conduct problems, and positive changes in scientifically established risk and protective factors for these problems.

Quality of Program - that the program's goals are explicit and clearly stated, and the program's goals are appropriate to the intended population and setting.

Usefulness to Others - that the program provides necessary information and guidance for replication in other settings.

IV. Background on County Prevention Activities

Part A, History: A brief history of the County's initiatives since the late 1970's to examine and coordinate substance abuse activities across agency lines.

Part B, Current Structure for Coordinating Prevention Activities: A description of standing committees and other groups established to coordinate one or more aspects of substance abuse prevention.

A. History

Between the late 1970's and the early 1990's, the Montgomery County Government convened a number of task forces and committees to address the County's substance abuse problems. These efforts resulted in several high-profile reports that offered recommendations for improving the County's response to drug and alcohol abuse. Many of the recommendations were implemented and are now part of the County's approach to the prevention and treatment of substance abuse. A number of inter-agency groups that operate today evolved from the County's focus on drug and alcohol abuse in the early 1990's.

The Interagency Planning Committee on Drug and Alcohol Abuse Led and CARE

In the late 1970's, the County Executive appointed the Interagency Planning Committee on Drug and Alcohol Abuse. In 1980, the Committee recommended the establishment of a "centrally located, broad-based resource center having the family as its special concern."

In response to the Committee's recommendation, in 1981 the County Government and Montgomery County Public Schools jointly established the **Community Awareness Resource Exchange (CARE) Center.** The primary role of the CARE Center was to serve as the County's information clearinghouse on alcohol, tobacco, and drug abuse information, with a special emphasis on prevention. As stated in the Center's 1986 annual report, its services (provided free to the public) included:

- Telephone and walk-in information and referral;
- Printed materials on substance use and abuse;
- Publication of service directories and a bimonthly newsletter;
- A library and film collection;
- A speakers bureau; and
- Creative, technical, and material support to prevention activities throughout the community.[1]

[1] *The Care Center, Year-End Report*, January-June 1986.

Initially staffed by a County employee in 1986, the County entered into a contract with a non-profit organization to operate the CARE Center, whose name was changed to the Prevention Center. Since 1996, the Montgomery County Community Partnership has operated the Prevention Center, under contract with the Department of Health and Human Services.[2]

The Community Leadership Task Force on Drug and Alcohol Abuse Prevention

In June 1988, the County Executive established the Community Leadership Task Force on Drug and Alcohol Abuse Prevention. The Task Force consisted of 39 members from community, business, and government organizations. The County Executive asked the Task Force to do four things:

1. Determine the extent of the substance abuse problem in the County;
2. Define specific target groups for prevention and education activities;
3. Identify action strategies; and
4. Identify the appropriate roles of community government schools, business, civic leaders, clergy, and families.[3]

The Task Force's interim report (September 1988) recommended that the County:

- Establish a County substance abuse policy;
- Prepare an inventory of prevention resources;
- Conduct a comprehensive information and media campaign;
- Develop an enhanced coordination infrastructure in the County Government;
- Educate employers and help them develop drug and alcohol policies;
- Conduct outreach in high-risk communities; and
- Build on natural tie-ins with other programs and events.

The Task Force's final report (June 1989) concluded that all of the above recommendations had been partly or completely implemented. The Task Force cited, for example, that progress had been made towards: establishing a substance abuse policy governing all County employees; developing enhanced coordination among all substance abuse programs within the County; preparing an inventory of available prevention resources; and conducting a comprehensive media campaign.

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[2] Each year, the Council has designated the Montgomery County Community Partnership as an entity on the non-competitive grant award list.

[3] Source: *Building a Drug-Free Community - The Final Report to the County Executive*, Community Leadership Task Force on Drug and Alcohol Abuse Prevention, June 1989.

The Task Force's final report also presented the County Executive with a Two-Year Action Plan. The Action Plan contained six goals and more than 100 specific steps to reach those goals. The goals were:

Goal 1: To empower the community -- neighborhoods, organizations and institutions-- to eliminate substance abuse by helping to build awareness, skills and resources.

Goal 2: To provide outreach and direct services programming to reduce substance abuse.

Goal 3: To conduct a broad public education and awareness campaign for substance abuse prevention.

Goal 4: To strengthen treatment and enforcement as prevention tools.

Goal 5: To ensure the ongoing monitoring and evaluation of prevention efforts in Montgomery County.

Goal 6: To seek creative funding for further prevention efforts.

The Task Force's final report also emphasized that prevention efforts must be sustained over time. In a section titled "The Future," the report stated:

> We must keep reminding ourselves that the commitment to prevention is a long-term promise. Many years of hard work are ahead of us if we are determined to succeed. Our goal is to have prevention take its rightful place as a sustained effort to deal with a sustained threat to our society. (*Building a Drug-Free Community*, p. 4.)

To ensure a sustained prevention effort, the Task Force recommended that an oversight committee be established for two years to monitor the implementation of the group's action plan. In July 1989, the County Executive appointed the Community Implementation Team (CIT) to "provide oversight and guidance to prevention activities in the County." The CIT combined County employees and community members.

Progress Report from the Special Assistant to the County Executive on Substance Abuse

In late 1988, the County Executive assigned, Dr. Maxine Counihan, (one of the CE's Special Assistants) to serve as Special Assistant on Substance Abuse. Dr. Counihan was charged with "coordinating the County's prevention, treatment, and enforcement efforts with all agencies--Board of Education, State's Attorney's Office, the Metropolitan Washington Council of Governments, the Community Leadership Task Force on Drug and Alcohol Abuse, et al.,--as well as efforts at the regional, State, and Federal level."[4]

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[4] *A Progress Report on Substance Abuse in Montgomery County*, submitted by Dr. Maxine Counihan, Special Assistant to the County Executive, December 1989, p. 4.

In 1988, the County Executive also established the Coordinating Council on Substance Abuse as a special interagency group. Dr. Counihan served as Chair of the Coordinating Council, which consisted of 28 senior government officials from County Government departments, the County Council, MCPS, the State's Attorney's Office, District Court, M-NCPPC Park Police, and the Housing Opportunities Commission. The Coordinating Council was asked to: review existing substance abuse policies and programs; identify gaps in services and develop new programs or reallocate resources in target areas; ensure a balanced system of approaches between prevention, treatment, and enforcement; and report regularly to the County Executive and other elected officials.

The Coordinating Council started out meeting bi-weekly. Over time, the Council schedule changed to monthly and finally quarterly meetings. The Coordinating Council had four standing committees that met more often: The Prevention Education Committee, the Neighborhood Empowerment Committee, the Grant Research Acquisition Committee, and the Youth Offenders Committee. (During the past decade, the Coordinating Council evolved into the current Substance Abuse Policy Leadership Team, described on page 41.)

In December 1989, Dr. Counihan issued *A Progress Report on Substance Abuse in Montgomery County*. The report summarized actions taken to address the problem of substance abuse in the County. In particular, the report highlighted interagency efforts including:

- Neighborhood Empowerment - a strategy to mobilize citizens to take control of their neighborhood to eliminate drug problems.

- Community Congress - a meeting of 215 persons who convened in November 1989 to implement the recommendation of the Community Leadership Task Force on Drug and Alcohol Prevention.

- Community Prevention and Education - an intensive outreach effort to business, religious organizations, Community Action Teams, and local civic organizations to promote awareness of substance abuse problems and develop local plans for education and prevention.

Progress Report from the Community Implementation Team

In June 1991, the Community Implementation Team issued its two-year progress report to the County Executive. In sum, the CIT reported that although progress had been made, substance abuse remained a serious problem in the County. The CIT's report cites three specific barriers to progress:

- An increase in the number and diversity of people needing services;
- Reductions in federal and private resources for prevention due to the national recession; and
- County-level budget cuts that negatively affected some of the direct services created to respond to the alcohol and other drug abuse problems in the County.

The CIT's progress report identified the challenge facing the County as one of keeping the spotlight on drug and alcohol prevention efforts while maintaining (and even expanding) these efforts despite limited resources. The report states that:

> The County Executive, agency and department heads, relevant coordinating and advisory groups, citizens, and community organizations must continue to give a high priority to the problems alcohol and other drugs continue to pose and reaffirm their commitment of resources and energy to address these issues. The partnership of community, business, schools, and government can take pride in what it has achieved since June 1989, but must firmly commit to continuing its cooperative efforts to build a drug-free community. (CIT Progress Report, p. 3)

In terms of progress on coordination and oversight, the report cited the establishment of the Coordinating Council on Substance Abuse (described earlier) and the planned merger of the Alcoholism Advisory Council and Drug Abuse Advisory Council into the Alcohol and Other Drug Abuse Advisory Council. (See page 43 for more about the Advisory Council, which continues to operate today.)

The CIT offered five specific recommendations for continuing prevention efforts in the County:

- Maintain strong organizational support for prevention efforts within the County government,
- Continue to focus prevention efforts on the same target groups: families with school-age children and communities with a high incidence of drug-related activities,
- Maintain public awareness of alcohol and other drug abuse issues and efforts,
- Continue supporting strong roles for enforcement and treatment agencies, and
- Expand evaluation of prevention programs.

Appendix M contains an excerpt from the CIT's report that expands upon each of these recommendations.

September 1993: Draft Prevention Policy

In 1993, the Director of the Department of Health and Human Services appointed a task force to draft a "Policy of the Montgomery County Government on the Prevention of Alcohol, Tobacco, and Other Drug Abuse." The group, consisting of 19 government and community representatives, submitted a draft policy in September 1993. As stated in the preamble:

> The purpose of this policy is to provide leadership and guidance to county, staff and agencies and a clear message to the entire community about the County Government's commitment to prevention. Because numerous studies indicate that most problems begin at early ages, this policy focuses primarily on children, youth, and families.[5]

[5] Draft Prevention Policy, December 1993, page 2.

The draft Prevention Policy proposed that the County Government take a "comprehensive" approach to prevention and ensure continuous and broad based prevention activities balanced both geographically and among the diverse cultural groups throughout the County. The draft Prevention Policy emphasizes that the prevention and treatment communities must work collaboratively and in cooperation with law enforcement, and that a balance (of funding and activities) must be maintained among prevention, treatment, and enforcement.

In terms of providing advice on funding, the draft Prevention Policy proposes that funding and other policy decisions be guided by the following:

- The critical role of traditional, long-standing youth programs that build resiliency and protective factors;
- The need to address and reduce the known risk factors which lead to the use of alcohol, tobacco, and other drugs;
- The importance of reaching all cultures and language groups in the County;
- Findings of national and local research on program effectiveness; and
- Elements of effective prevention programs, including: needs assessment, clear and measurable goals, effective leadership, planned evaluation that measures success, and program revisions to improve effectiveness.[6]

Note: The draft Prevention Policy was never formally endorsed by either the County Executive or County Council. Appendix N contains a full copy of the draft.

"Joining Forces" - A Retreat of Prevention Professionals in May 2000

In May 2000, the Department of Health and Human Services' Office of Public Health Services held a one-day retreat with 35 individuals representing various County agencies and community organizations to discuss issues related to preventing the abuse of alcohol, tobacco, and other drugs in the County.

Appendix O contains the summary report of the one-day retreat. In sum, the group agreed that:

- Because prevention of alcohol and other drug abuse includes educating the public about the dangers of substance use, providing positive alternatives for people of all ages, and strengthening family ties and community life, almost all of the County's public and private programs and all segments of County life must be enlisted in prevention work;
- Effective prevention programs build on the assets of individuals, families and communities, and
- Having a shared framework of prevention programs helps maximize public and private resources.

[6] Draft Prevention Policy, December 1993, page 6.

The group identified the following needs:

1. **Complete a comprehensive list of prevention initiatives across the County**. This task was begun in 1998 by Department of Health and Human Services staff.

2. **Build a stronger partnership among prevention professionals.** Suggestions to do this included: expanding the list of retreat participants, developing a ListServ to connect those involved with prevention developing a "business/marketing" plan for prevention work; and updating the 1993 Prevention Policy.

B. Current Structure for Coordinating Prevention Activities

An array of committees, councils, coalitions, and other groups in Montgomery County currently work on ATOD prevention activities for school-age youth. This section begins with a brief description of the State's Alcohol and Drug Abuse Administration (ADAA)'s County Prevention Network system; it then identifies the different County groups and summarizes their respective purposes and membership.

Note to reader: The scope of this OLO report did not include an independent review of how these various groups function in practice, i.e., who actually attends meetings, to what extent the group actually fulfills its stated purpose, and whether participants are satisfied with the group's structure and activities. As a result, the information presented below reflects what has been formally written-up about the group and/or information provided by the group's staff.

State Requirement for a Prevention Coordinator

The mission of the State Alcohol and Drug Abuse Administration (ADAA) is to plan, develop, coordinate, and deliver services to prevent harmful involvement with alcohol and other drugs and to treat the illness of chemical addiction.[7] ADAA's Prevention Services Division acts as the State's liaison to the "County Prevention Coordinator Network," which consists of Prevention Coordinators designated by each of the State's 24 political subdivisions.

According to ADAA's Prevention Network Strategy, the role of each Prevention Coordinator is to communicate with and serve as a community resource for prevention program planning and community building. ADAA defines the scope of the Prevention Coordinators' responsibilities as broad and based upon the concept of prevention as a life long process. Specifically, ADAA expects that each Prevention Coordinator will:

> Work closely with all elements of the community including schools, human services agencies, youth services agencies, substance abuse treatment programs, neighborhood organizations, businesses, parent groups, religious groups, and law enforcement officials to identify needs, develop substance abuse projects, and obtain funding.

[7] ADAA is part of the State's Department of Health and Mental Hygiene. It is structurally located under the Deputy Secretary for Public Health Services.

Montgomery County's designated Prevention Coordinator works in the Health Promotion and Prevention Section in the Department of Health and Human Services.

Current Roster of Committees and Groups

The table below lists the committees and other groups in Montgomery County involved with ATOD prevention activities for school-age youth. Some of these groups were created more than a decade ago; others came into existence only recently.

Several of the groups include only government agency representatives, but most also include representatives from outside the government. A number of the groups target a specific substance (i.e., tobacco use, alcohol use) while others deal with all types of substance use and abuse. Many of the same individuals participate in more than one of the listed groups.

TABLE 5
GROUPS INVOLVED IN ATOD PREVENTION FOR SCHOOL-AGE YOUTH

Name of Group	When Established	Origin of Group	Current Frequency of Meetings
The Prevention Network	Mid-1980's	DHHS Initiative	Bi-monthly
Substance Abuse Policy Leadership Team (formerly the Coordinating Council on Substance Abuse)	1989	County Executive	Quarterly
Safe and Drug Free Schools Advisory Council	1989	Federal law	Monthly
Montgomery County Community Partnership	1990	Federal grant	Quarterly
Alcohol and Other Drug Abuse Advisory Council	1991	County law	Monthly
Drawing the Line on Underage Alcohol Use	1992	Councilmember Initiative	Monthly
Healthy Montgomery Coalition	1993	DHHS Initiative	Bi-monthly
Tobacco Use Prevention & Cessation Coalition - Cigarette Restitution Fund	2000	State Law	Monthly
School Health Council	2000	State Law	Quarterly
Collaboration Council- Ad Hoc Youth Strategies Consolidated Grant Work Group	2001	Collaboration Council Initiative	As needed
Hospitality Resource Panel	2001	DHHS Initiative	Ad-hoc

Source: OLO & agency staff, February 2002.

For each of the groups listed in the table above, the rest of this chapter provides summary information about their respective purpose(s) and membership.

THE PREVENTION NETWORK

Purpose: The stated purpose of the Prevention Network is to provide prevention professionals, grassroots organizations, and community coalitions with opportunities to develop, network, and share information concerning ATOD prevention. The Prevention Network's meeting schedule has varied over the years. Today, DHHS staff convene Prevention Network meetings six times a year.

Membership. DHHS staff reports that attendance at Prevention Network meetings ranges from 10-20 individuals. Most participants are either current or former mini-grant recipients. (See Appendix A ©64 or a description of the mini-grant program.) During the past several years, individuals from the following organizations have attended one or more Prevention Network meetings:

- City of Gaithersburg
- City of Rockville
- Montgomery County Community Partnership
- Montgomery County Public Schools
- MCCPTA
- GUIDE Youth Services
- Family Support Center
- Housing Opportunities Commission
- Head Start
- Baptist Home for Children
- Project Prom Graduation
- Project Pride
- Hyatt Regency Bethesda
- Young Friends in Action
- B-CAT Prevention Network
- Kennedy Cluster SCAT
- Ephesians Life Ministries
- Family Learning Solutions
- Parent Warmline
- Interages
- Department of Health and Human Services
- Department of Recreation
- Drawing the Line on Underage Alcohol Use
- CASA of Maryland
- Mental Health Association
- National Council of La Raza
- Community Ministries of Rockville
- Bethesda YMCA- Youth Services
- Silver Spring YMCA- Youth Services
- UpCounty YMCA
- Kensington Wheaton Youth Services
- Bullis School
- Parkland Middle School
- Chevy Chase Elementary School
- Collaboration Council
- Catholic Charities
- Community Well
- State's Attorney's Office
- Blue Cross/Blue Shield
- MADD

THE SUBSTANCE ABUSE POLICY LEADERSHIP TEAM (SAPLT)

Purpose: The Substance Abuse Policy Leadership Team (SAPLT) evolved from the Coordinating Council on Substance Abuse established by the County Executive in 1988.[8] Today, the SAPLT is an inter-agency group that meets quarterly to discuss issues related to substance abuse prevention, treatment and enforcement. The Director of the Department of Health and Human Services chairs the SAPLT. The County's Prevention Coordinator provides staff support to the SAPLT in terms of setting the agendas, sending out meeting notices, and maintaining records.

Membership: When it was established in 1988, the Coordinating Council consisted of 28 senior government officials from County Government departments, the County Council, MCPS, State's Attorney's Office, District Court, Park Police, and Housing Opportunities Commission.

According to DHHS staff, today's SAPLT membership is much more informal. Many individuals from a broad range of departments and agencies are invited to attend. Some individuals attend regularly while others rarely attend at all. DHHS staff persons attend every SAPLT meeting. Within the past year, representatives from the following other offices also attended one or more SAPLT meetings:

- Montgomery County Police Department
- UpCounty Regional Services Center
- Public Works and Transportation
- Office of the Sheriff
- Park Police
- Office of Legislative Oversight
- Montgomery County Community Partnership
- Silver Spring Regional Services Center
- Office of Human Resources
- Housing Opportunities Commission
- M-NCPPC
- Department of Correction and Rehabilitation
- Montgomery County Public Schools

SAFE AND DRUG FREE SCHOOLS ADVISORY COUNCIL

Purpose: Established in 1989 when the Safe and Drug Free School (SDFS) program began, the Advisory Council is mandated by the Federal Safe and Drug Free Schools and Communities Act. The stated purpose of the Advisory Council is to provide oversight in the implementation of the SDFS program in Montgomery County.

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[8] See earlier description of the origin of the Coordinating Council on Substance Abuse in 1988, page 35.

Membership: The Advisory Council consists of a representative from MCCPTA and representatives from different MCPS high school clusters. A representative from the Damascus Cluster currently chairs the Advisory Council. The other high school clusters currently represented on the Advisory Council are:

- B-CC
- Walter Johnson
- Northwest
- Wootton
- Sherwood
- Einstein
- Churchill
- Gaithersburg
- Kennedy
- Watkins Mill
- Paint Branch

MONTGOMERY COUNTY COMMUNITY PARTNERSHIP

Purpose: The Montgomery County Community (MCCP) Partnership is a non-profit organization created in 1990 through grant support from the Center for Substance Abuse Prevention. It received its 501(c)(3)-status in September 1993. MCCP is governed by a Board of Directors that consists of representatives from government, schools, law enforcement, youth, parents, religious community, elected officials, business, media, and other grassroots community groups.

MCCP describes itself today as a "a community coalition working to reduce the problems related to alcohol, tobacco, and other drugs," and as an organization "dedicated to applying current research in promoting effective policies and practices to prevent alcohol, tobacco, and other drug abuse."

Over the years, financial support for MCCP has come from a combination of County and non-County sources. Currently, the Federal Office of Juvenile Justice and Delinquency Prevention and the Montgomery County Department of Health and Human Services provide MCCP's primary funding; Montgomery County Public Schools also contributes some funds each year to support MCCP's operations.

Membership: According to the Partnership's "Fact Sheet of Services" the MCCP brings together more than 100 organizations and individuals interested in substance abuse and prevention issues.[9] MCCP 18-member Board of Directors is currently co-chaired by representatives from the Montgomery County Civic Foundation and Adventist Health Care.

[9] Source: MCCP's website.

Other Board members represent the following organizations and businesses:

- Suburban Hospital
- Smoke Free Montgomery County Coalition
- Montgomery County Council of Parent-Teacher Associations
- Montgomery County Police Department
- Leonard Communications
- Montgomery County Youth Advisory Committee
- Task Force on Mentoring of Montgomery County
- The Woman's Club of Chevy Chase
- The Black Ministers Conference of Montgomery County
- National Institute on Drug Abuse
- Montgomery County Public Schools
- MCPS - Safe and Drug Free Schools Bradley Care Drugs
- NAACP Montgomery County Branch

In addition, a State delegate and a number of individual community members serve on the MCCP Board.

ALCOHOL AND OTHER DRUG ABUSE ADVISORY COUNCIL

Purpose: County law established the Alcohol and Other Drug Abuse Advisory Council in the early 1990's. It replaced two longstanding advisory groups - the Alcoholism Advisory Council and the Drug Abuse Advisory Council. The stated purpose of the Alcohol and Other Drug Abuse Advisory Council is to:

- Identify local alcohol and other drug abuse program needs;
- Review the State alcohol and other drug abuse plan;
- Assist in the development of the County alcohol and other drug abuse plan;
- Consider available funding and recommend appropriate allocation of funds to support alcohol and other drug abuse programs;
- Promote alcohol and other drug abuse programs;
- Conduct or participate in one or more pubic forums each year concerning alcoholism and other drug abuse; and
- Issue an annual report to the County Executive, County Council, and Director of DHHS.

The Advisory Council meets once a month. Staff support for the Council is provided by the Department of Health and Human Services.

Membership: By law, the Alcohol and Other Drug Abuse Advisory Council consists of 16 voting members and 9 non-voting members. The voting members, appointed by the County Executive and confirmed by the County Council, must include:

- Four members of the general public that reflect the geographic diversity of the County
- A professional who treats alcoholism or other drug abuse
- A person of high school age or younger
- A member of the County parent-teacher associations
- A member of the business community
- A relative of an individual who is receiving care for alcoholism or other drug abuse
- An individual who is recovering from alcoholism or other drug abuse
- A practicing physician
- A professional who provides care to prevent alcoholism or other drug abuse
- A person who represents the multi-cultural diversity of the County
- A member of the clergy
- A pharmacist
- A member of the legal profession

The nine non-voting ex-officio members are designated by: the County Executive, County Council, Health and Human Services Department, Police Department, MCPS, Board of License Commissioners, Department of Corrections, Mental Health Advisory Committee, and Advisory Board on Victims and their Families.

DRAWING THE LINE ON UNDERAGE ALCOHOL USE

Purpose: Drawing the Line on Underage Alcohol Use (DTL) was established in 1992 with the following two goals: (1) To change the public perception regarding underage alcohol use; and (2) To change policies, procedures, and laws regarding alcohol use. County Councilmember Gail Ewing is credited as being the driving force behind establishing the initial DTL Coordinating Committee in 1992.

An October 2001 briefing book (prepared by DTL staff) describes DTL as follows:

> DTL is a multi-agency, public-private, comprehensive, county-wide program aimed at creating community consensus that underage drinking is unhealthy, illegal, and unacceptable. Based on social marketing principles and the latest prevention research, the program brings together existing efforts and channels new initiatives to change the environment in which young people operate. Youth behavior is changed by getting adults to change the climate in which children grow up and live. (DTL, October 2001)

DTL's participant roster lists more than 30 "partners" including government officials, civic groups, non-profit organizations, and businesses. DTL's reports cite the following activities as ways DTL pursues its goal of changing attitudes and behavior of both adults and young people:

- Enforcement of the laws by the police and Board of License Commissioners and attention to the seriousness of alcohol-related offenses involving minors by the Department of Juvenile Services and the judiciary;
- Educational programs for adults and youth through schools, parent organizations, the media, and community groups;
- Alcohol-free activities for youth sponsored by restaurants, businesses, schools, recreation departments, and community groups;
- Assessment and referral for treatment or education as appropriate for youth found using alcohol; and
- Advocacy for new laws and policies to make it more difficult for youth to drink.[10]

Over the years, financial support for DTL's activities has come from a combination of County and non-County sources. The Department of Health and Human Services currently funds a half-time coordinator position; this funding is part of DHHS' contract with the Montgomery County Community Partnership.

Membership. DTL's current roster of "Active DTL Partners" lists one or more representatives from the following government agencies, departments, and organizations:

- Montgomery County Police Department
- Criminal Justice Coordinating Commission
- Board of License Commissioners
- Department of Liquor Control
- Kensington Volunteer Fire Department
- M-NCPPC Park Police
- Maryland Hospitality Education Foundation
- National Highway Safety Traffic Administration
- Montgomery County Community Partnership
- Georgetown Prep. Community of Concern
- Hyatt Hotels and Resorts
- Counter Parts, Inc
- RMA, Inc
- Community Well
- Department of Health and Human Services
- Department of Recreation
- B-CC Regional Services Center
- Department of Correction and Rehabilitation
- Montgomery County Public Schools
- District Court
- Collaboration Council
- State's Attorney's Office
- State Department of Juvenile Justice
- Damascus SCAT
- Project Prom Graduation
- Leonard Communications
- Emergency Nurses CARE

[10] Source: Drawing the Line on Underage Alcohol Use, Brief Book, October 2001.

HEALTHY MONTGOMERY COALITION

Purpose: The Healthy Montgomery Coalition (HMC) was formed in 1993 by the then Department of Health to identify health promotion priorities for Montgomery County. Over the years, HMC has focused on different issues. The Coalition's current purpose is:

- To stay informed about key public health issues affecting Montgomery County residents and advocate for appropriate policies; and

- To achieve uniform enforcement of school smoking policies in all Montgomery County Public Schools.

Membership: The HMC is currently co-chaired by representatives from the Montgomery County Community Partnership and Holy Cross Hospital. According to DHHS staff, representatives from the following organizations work with the HMC:

- Montgomery General Hospital
- Holy Cross Hospital
- Suburban Hospital
- Montgomery County Public Schools
- MCC-PTSA
- Primary Care Coalition
- American Cancer Society
- Mental Health Association
- Doctors Against Tobacco
- Metropolitan Washington Public Health Association
- Department of Health and Human Services
- Department of Libraries
- Foundation for Health Education
- American Lung Association of MD
- Montgomery County Community Partnership
- Cooperative Extension Services
- Lion's Club

TOBACCO USE PREVENTION & CESSATION COALITION - CIGARETTE RESTITUTION FUND

Purpose: The Tobacco Use Prevention and Cessation Coalition was created to advise the County Government on how to best utilize the Cigarette Restitution Fund monies that the County receives for the development of education, prevention, and tobacco cessation programs. The Coalition aims to expand programs that will prevent tobacco use and promote tobacco use cessation. It also aims to reduce the rates of morbidity and mortality from tobacco related diseases in Montgomery County.

Membership: The Coalition consists of representatives from the following agencies, associations, and organizations:

- Quit While You're Ahead
- Montgomery County Community Partnerships
- Department of Health and Human Services
- American Cancer Society
- American Lung Association
- Doctors Against Tobacco
- The Mission
- Identity Inc.
- Montgomery College
- Department of Recreation
- Montgomery County Public Schools
- Asian American Anti-Smoking Foundation
- The Baobab Tree Project
- Smoke Free Montgomery County Coalition
- Adventist HealthCare

SCHOOL HEALTH COUNCIL

Purpose: State law requires the County to establish a School Health Council. In May 2000, the Medical Advisory Committee of the Board of Education transformed into the Montgomery County School's Health Council. The School Health Council reports jointly to the Superintendent of Schools and to the County Government's Health Officer. Staff support is jointly provided by MCPS (Office of Student and Community Services) and DHHS (School Health Services).

The stated purpose of the School Health Council is to:

- Provide a forum for school health concerns;
- Promote and support "comprehensive school health";
- Provide recommendations on school health issues;
- Obtain community input;
- Promote cooperation between health and educational agencies; and
- Promote public-private partnerships for school programs.

Membership: The School Health Council for the current school year (2001-2002) is co-chaired by a representative from the Montgomery County Medical Society and the Chair of the MCCPTA Health Committee.

Members of this year's School Health Council are representatives from the following organizations:

- Montgomery County Board of Education
- DHHS-Public Health Services
- MCPS-Safety Office
- MCPS-Guidance Unit
- Montgomery County Collaboration Council
- Montgomery County Council of PTAs
- Montgomery County Medical Society
- Primary Care Coalition
- Cigarette Restitution Settlement Task Force
- Montgomery County Council
- DHHS-Health Promotion and Prevention
- MCPS-Health Education
- MCPS-Office of Student Services
- Montgomery County Commission on Health
- Southern Maryland Dental Society
- Montgomery County Workforce Development Corporation
- Mental Health Association of Montgomery County
- Linkages to Learning

In addition, there is a student representative, a community representative, and two slots allocated for principal representatives.

COLLABORATION COUNCIL - AD HOC YOUTH STRATEGIES CONSOLIDATED GRANT WORK GROUP

Purpose: Montgomery County's Collaboration Council for Children, Youth and Families, established in 1992, is a public-private partnership policy board that serves as Montgomery County's State-required Local Management Board (LMB). In 1990, State legislation was enacted that required each local jurisdiction in Maryland to establish a LMB as "the conduit for local collaboration and coordination of child and family services." Today, Montgomery County's Collaboration Council is one of the 24 LMBs in Maryland. The Governor's Office of Children, Youth and Families manages LMB grants and provides technical assistance to the LMBs.

The Ad Hoc Youth Strategies Consolidated Grant Work Group is part of the Systems Strategies Committee of the Collaboration Council. The Ad Hoc Work Group began in September 2001 as the planning mechanism for the Youth Strategies Consolidated Grant proposal to the Governor's Office of Crime Control and Prevention (GOCCP). The GOCCP brought together several federal and state funding sources and charged the Local Management Board with creating a plan and proposal which addressed prevention through aftercare, using effective programs and practices. The Ad Hoc Work Group referenced the *Montgomery County Comprehensive Strategy - A Juvenile Justice Plan* and *The Children's Agenda* in its proposal development.

In January 2002, the Collaboration Council received a grant award of $1.4 million to support a variety of programs, all designed to prevent involvement with or to assist children and youth currently involved with the juvenile justice system or substance abuse. A combination of public and private agencies will deliver the services and the Collaboration Council will maintain oversight, monitoring, evaluation, and reporting responsibilities.

The stated goals of the Collaboration Council (as a whole) are:

- To develop, promote, and implement a comprehensive "agenda" for Montgomery County's children and families;
- To promote collaborative partnerships among public and private public service providers;
- To recommend to the County Executive, County Council, and Board of Education priorities and strategies that promote community participation in achieving the core outcomes;
- To partner with state and local government to improve the delivery and financing of the human service system;
- To evaluate the effectiveness of strategies to improve the well-being of children and families, the cross-agency community efforts to improve systems, and the Council's progress; and
- To increase readiness and ability to implement the community agenda.[11]

Membership: The Collaboration Council (as a whole) is currently co-chaired by a representative from the Department of Health and Human Services and a community representative. The Collaboration Council's bylaws require it to have 51% of its 28 members to be public agency representatives. The remaining 49% are private providers and community representatives

Public agency representatives currently include:

- Department of Health and Human Services
- The County Executive
- Montgomery County Council
- Montgomery County Board of Education
- Montgomery County Public Schools
- Montgomery County Police Department
- Montgomery County Core Service Agency
- Maryland Department of Juvenile Justice
- Housing Opportunities Commission
- Maryland District Court for Juveniles (now part of Family Court in Circuit Court)

Private providers and community representatives currently include:

- Montgomery County Council of PTAs
- Montgomery County Community Foundation
- Montgomery County Business Roundtable for Education
- Mental Health Association of Montgomery County
- Reginald S. Lourie Center

In addition, there is a representative from the business community, the faith community, a parent, and several community advocates.

[11] Source: Collaboration Council documents.

The following public partners were involved with the Ad Hoc Planning Group: the Department of Health and Human Services; Department of Recreation; Montgomery County Police Department; the Early Childhood Initiative; Montgomery County Public Schools, Department of Juvenile Justice; Circuit Court; District Court; and the State's Attorney's Office.

MONTGOMERY COUNTY - HOSPITALITY RESOURCE PANEL

Purpose: The purpose of the Hospitality Resource Panel is to develop safe communities and healthy businesses through the promotion of responsible alcohol service. It is an alliance of business associations, public agencies, educators, prevention community members, enforcement officials, and alcohol suppliers. The Department of Health and Human Services currently funds a part-time coordinator position for the HRP; this funding is part of DHHS' contract with the Montgomery County Community Partnership.

Membership: In addition to participants from the business community, County Government departments actively involved with the HRP are: Department of Health and Human Services; Police Department; Board of License Commissioners; Department of Recreation; and the Department of Liquor Control.

V. Prevention Programs for School Age Youth in Montgomery County: FY 02 Inventory and Fiscal Analysis

As part of this IBR project, OLO worked with agency staff to compile a list County programs that cite as one of their primary goals: to delay, reduce, and/or prevent altogether the use of alcohol, tobacco, and other drugs (ATOD) by school-age youth.

- This chapter reviews the FY 02 inventory of prevention programs for school-age youth.

- The next chapter (Chapter VI, beginning on page 73) outlines how the agencies' FY 03 budget requests might change the FY 02 inventory and/or funding of ATOD prevention programs for school-age youth.

The inventory includes 32 programs that received a total of $6.7 million in FY 02. Of the total funding for these prevention programs, $2 million or 30% is non-County funds, primarily state and federal grants. The 32 programs are administered by:

- Montgomery County Public Schools;
- County Government Departments of Health and Human Services, Police, Recreation, and Community Use of Public Facilities;
- Housing Opportunities Commission;
- Office of the Sheriff, and
- M-NCPPC Park Police.

For some of the programs, e.g., the Safe and Drug Free Schools Project, the Prevention Center, and DARE, substance abuse prevention activities account for all or almost all of the program's funding. For others, e.g., School Health Services and MCPS health curriculum, substance abuse prevention activities represent only one among many program components. For these programs, OLO and agency staff agreed to include in this IBR project an estimated portion of the total program costs.

Part A provides a broad overview of the total FY 02 funding (County and non-County) appropriated by department/agency for the inventory of prevention programs.

Part B looks at how the FY 02 funds appropriated for programs in the inventory are divided among:

- The Institute of Medicine's three categories of prevention programs - universal, selective, and indicated; and

- The Center for Substance Abuse Prevention's six categories of prevention strategies: information dissemination, prevention education, alternative activities, problem identification/referral, community based process, and environmental approaches.

Part C lists the specific programs and activities included in the inventory of prevention programs, and shows FY 02 County and non-County funding levels for each program/activity. It also includes a list of related programs identified during the course of research for this report.

Appendix A contains a program-by-program description of items included in the inventory; and Chapter VII (beginning on page 81) summarizes for programs in the inventory the performance measures collected, tracked, and reported.

A. Overview of Prevention Funding

In FY 02, the County Council appropriated $6.7 million in County and non-County funds to support the inventory of prevention programs.[1] The pie graphs on page 53 depict the distribution of the $6.7 million and the bottom-line division between County and non-County funds. For each agency/department, Table 6 (page 54) lists the total amount of County and non-County funds appropriated.

In sum, of the $6.7 million appropriated in FY 02 to programs in the inventory of prevention programs:

- County funds constitute $4.7 million or 70% of the $6.7 million; the $2 million in outside funds are primarily state and federal grants.

- Outside funds constitute significant amounts spent on prevention by the Montgomery County Public Schools, the Department of Health and Human Services, and the Housing Opportunities Commission.

- The Department of Health and Human Services received $2.1 million and the Montgomery County Public Schools received about $1.9 million for prevention activities; together these two agencies account for 60% of the total funds.

- The Department of Police and Department of Recreation each received about $1 million for prevention activities, and together account for another 32% of the total funds.

- Four agencies split the remaining 10% of the $6.7 million: the Housing Opportunities Commission ($0.5 million); Office of the Sheriff ($77K); the M-NCPPC Park Police $43K and to the Community Use of Public Facilities ($14K).

[1] Technically, the Council appropriated all of the FY 02 funds under discussion except for the Drug Elimination Grant ($384K), which the Housing Opportunities Commission received directly from the federal government. While these grant funds were included in the full HOC budget that was reviewed and approved by the Council, Council appropriation of these grant funds is not legally required.

CHART 3: COUNTY VS. NON-COUNTY FUNDS APPROPRIATED FOR ATOD PREVENTION FY 02

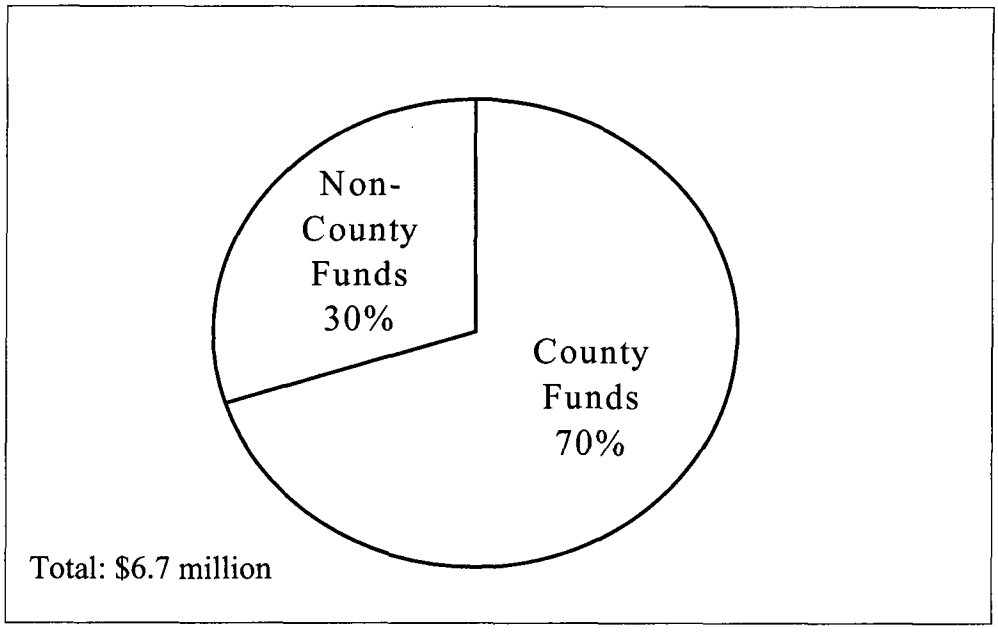
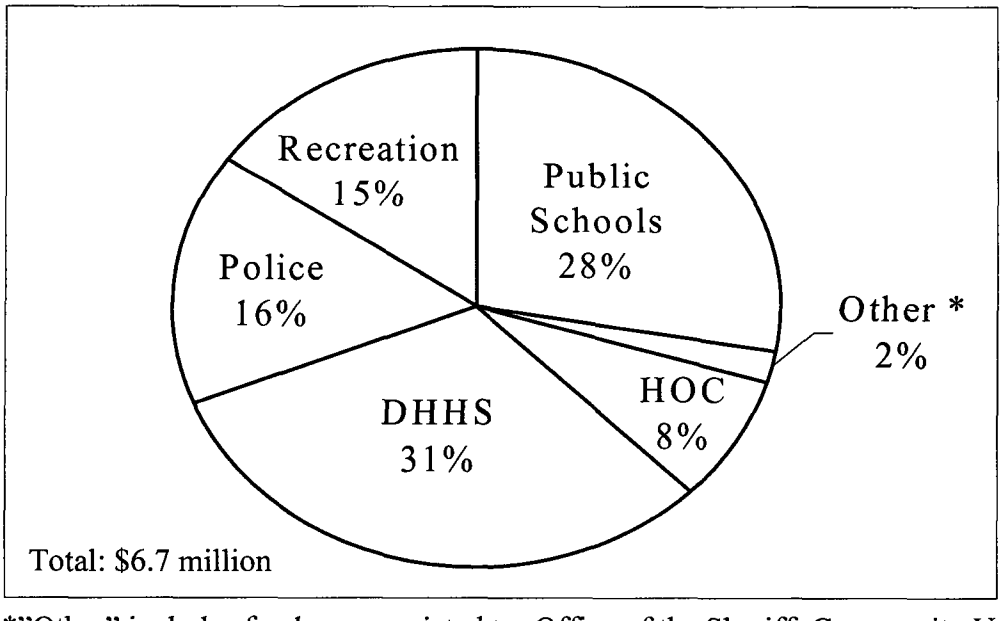


CHART 4: FUNDS APPROPRIATED FOR ATOD PREVENTION BY AGENCY/DEPARTMENT FY 02



*"Other" includes funds appropriated to: Office of the Sheriff, Community Use of Public Facilities, and M-NCPPC Park Police

TABLE 6
COUNTY AND NON-COUNTY FUNDS FOR PREVENTION PROGRAMS BY AGENCY, FY 02

Agency/Department	County Funds ($ in 000's)	Non-County Funds* ($ in 000's)	Total ($ in 000's)
Montgomery County Public Schools	$1,238	$633	$1,871
Housing Opportunities Commission	$130	$384	$514
M-NCPPC - Park Police	$43	$0	$43
Office of the Sheriff	$77	$0	$77
County Government			
Department of Health & Human Services	$1,204	$927	$2,131
Police Department	$993	$66	$1,059
Recreation Department	$1,019	$12	$1,031
Community Use of Public Facilities	$14	$0	$14
TOTAL	**$4,718**	**$2,022**	**$6,740**

Source: OLO & agency staff, March 2002

*The approximately $2 million in non-County funds for prevention includes a number of situations where grant funds are received by one entity and passed along or shared with another. The tables in this chapter report the outside funds next to the agency/department where the Council formally appropriates these funds.

More about Non-County Funding for Prevention

In FY 02, non-County sources of funds account for approximately two million or 30% of the total $6.7 million appropriated to programs in the inventory. Table 7 (page 56) lists the sources, amounts, and recipients of this $2 million.

The bar chart on page 57 depicts the County vs. non-County funding for ATOD prevention by agency/department. The chart illustrates that significant portions of the total funding for prevention activities sponsored by MCPS, DHHS, and HOC came from non-County sources.

In FY 02, the largest single infusion of outside funds is the Safe and Drug Free Schools and Communities Act grant received by MCPS through the State Department of Education. MCPS uses most of these funds to support a range of prevention activities organized through the Safe and Drug Free Schools Project. A portion of these funds ($11K) is used to purchase instructional supplies for the DARE program.

From a number of different sources, the Department of Health and Human Services obtained almost $1 million in outside grant funds for prevention in FY 02. The largest grant amounts came from the State Alcohol and Drug Abuse Administration ($490K) and the Cigarette Restitution Fund ($398K). DHHS passes on some of the ADAA funds to the Recreation Department for alternative activities related to prevention, and shares some of the Cigarette Restitution Fund money with MCPS and the Recreation Department.

For the past decade The Housing Opportunities Commission has funded most of the agency's prevention activities with federal Drug Elimination Grant funds.[2] In FY 02, about 75% of HOC's prevention activities organized for youth and other family members in HOC's public housing complexes are funded through the agency's $384K Drug Elimination Grant. **This grant program, administered by the federal Department of Housing and Urban Development, will be discontinued as of the end of the current federal fiscal year.**

[2] As noted earlier, these grant funds are received directly by HOC and expenditure of these funds does not require Council appropriation.

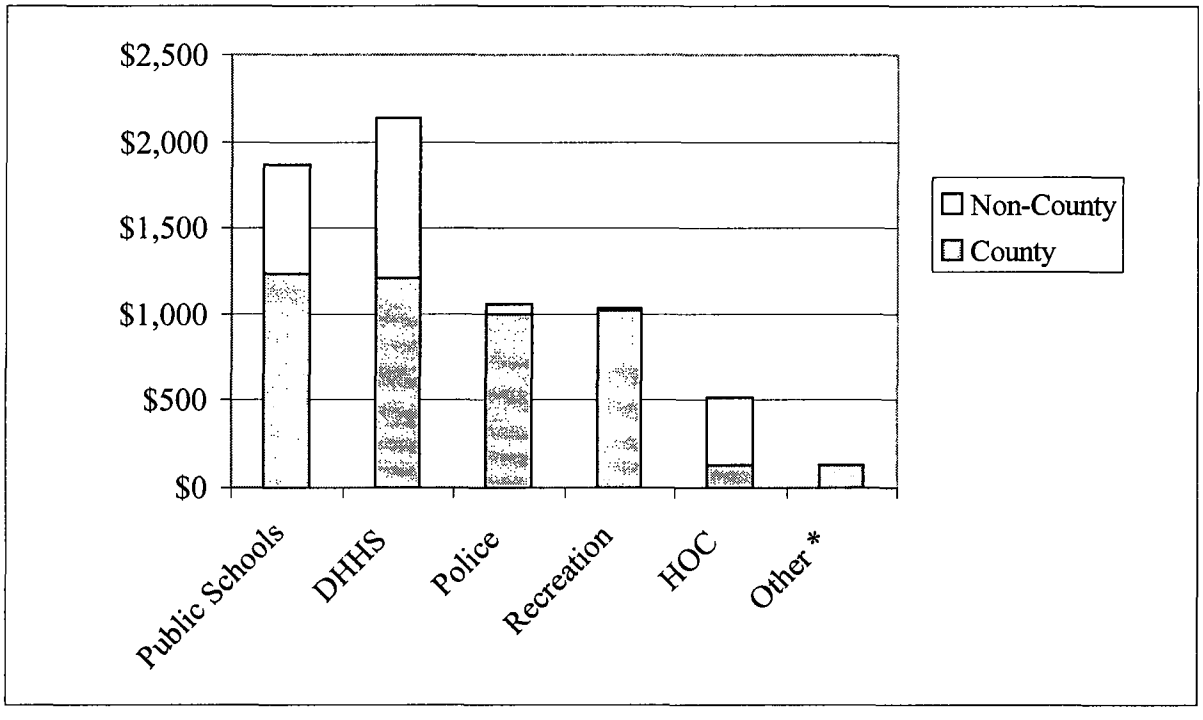
TABLE 7
SOURCE, AMOUNTS, AND PROGRAMS SUPPORTED IN FY 02 WITH NON-COUNTY FUNDS

Source of Non-County Funds	Amount ($ in 000's)	Prevention Programs Supported* ($ amount received)
Safe and Drug Free Schools and Communities Act	$566	• Safe and Drug Free Schools Project ($555K) • DARE - ($11K for instructional supplies)
Alcohol and Drug Abuse Administration (ADAA)	$490	• Screening Assessment Services for Children and Adolescents ($101K) • The Pre-School Program ($142K) • Teen Leadership Program ($46K) • Mini-Grant Program ($80K) • Prevention Technical Assistance ($62K) • Prevention Literature Review ($13K) • Hospitality Resource Panel ($6K) • The Prevention Network ($5K) • Under-21 Grants ($3K) • Drawing the Line on Underage Drinking ($2.5K) • Administrative costs/overhead ($29K)**
Cigarette Restitution Fund (CRF)	$398	• School Health Services ($248K) • Teen Tobacco Prevention ($90K) • MCPS' middle school health curriculum ($45K) • Teen After School ($15K)
Drug Elimination Grant – Federal	$384	The Housing Opportunities Commission -Drug Elimination Program ($384K)
High Intensity Drug Traffic Area (HIDTA)**	$50	The HOME Project ($50K)
Tobacco Use Prevention Grant	$48	MCPS' middle and high school health curriculum ($48K)
Montgomery County Community Partnership (MCCP)	$25	Screening Assessment Services for Children and Adolescents ($25K)
Local Law Enforcement Block Grant	$15	Police Activities League ($15K)
Inter-Agency Council for Adolescent Pregnancy	$15	School Health Services ($15K)
State Physical Fitness Grant	$12	Teen After School ($12K)
Private sector donations	$13	MCPS' Character Education ($12K)
Delinquent and Youth at Risk of Dropping out Grant	$7	Phoenix I/II ($7K)
TOTAL	**$2,022**	

*The programs listed are funded either in whole or in part by outside funds.

**Includes DHHS' cost of grant administration and program evaluation.

CHART 5: FUNDS APPROPRIATED FOR ATOD PREVENTION BY AGENCY/DEPARTMENT COUNTY VS. NON-COUNTY FUNDS, FY 02 ($ IN 000'S)



*"Other" includes funds appropriated to: Office of the Sheriff, Community Use of Public Facilities, and M-NCPPC Park Police

B. Two Ways of Looking at Prevention Funding in the County

This section looks at how the FY 02 funds appropriated for programs in the inventory are divided among:

- The Institute of Medicine's three categories of prevention programs - universal, selective, and indicated; and

- The Center for Substance Abuse Prevention's six categories of prevention strategies: information dissemination, prevention education, alternative activities, problem identification/referral, community based process, and environmental approaches.

1. Spending among Universal, Selective, and Indicated Prevention Programs[3]

The Institute of Medicine (IOM) divides substance abuse programs into three categories: prevention, treatment, and maintenance. The IOM and Substance Abuse and Mental Health Services Administration (SAMHSA) further divide the substance abuse prevention category into three classifications:

Universal programs target either the general population or a segment of the population who share the same general risks in terms of probability of alcohol, tobacco, and other drug (ATOD) use.

Selective programs target specific subgroups whose risk of substance use is significantly higher than the general population's.

Indicated programs target high-risk individuals who are already substance users or who exhibit behaviors or whose living circumstances put them at notably higher risk for ATOD use and/or addiction.

OLO worked with agency staff to sort programs according to whether they are universal, selective, or indicated prevention programs. For programs that involve activities in more than one category, program costs were split accordingly. Table 8 (page 59) summarizes how funds appropriated across the agencies are allocated among these three program categories.[4]

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[3] Appendix C contains more detailed explanations and examples of programs in each IOM category.

[4] The total $6.6 million divided among the three IOM categories is less than the total $6.7 identified earlier in this chapter due to $104K in administrative costs (from MCPS, DHHS, and the Recreation Dept. not attributed to specific programs.

TABLE 8
FUNDING FOR UNIVERSAL, SELECTIVE, AND INDICATED PREVENTION PROGRAMS, FY 02
($ in 000s)

Source of Funds	Universal Programs	Selective Programs	Indicated Programs	Total
County	$3,254	$998	$460	$4,712
Non-County	$910	$943	$67	$1,920
Total	$4,164	$1,941	$527	$6,632*
% of Total Funding	63%	29%	8%	100%

*The total $6.6 million distributed among the three categories is less that the total $6.7 million identified earlier in the chapter due to $108K in administrative costs (from MCPS, DHHS, and Recreation Dept.) not attributed to specific programs.
Source: OLO and agency staff, March, 2002

In sum, out of the $6.6 million allocated to ATOD prevention programs for school-age youth in FY 02:

$4.2 million (63%) fund universal prevention programs. Major FY 02 expenditures in this category are:

- **Classroom prevention education by MCPS teachers** - MCPS spends an estimated $0.7 million to teach ATOD prevention as part of the required health curriculum taught at every grade level. The breakdown of estimated costs is $0.5 million for elementary ATOD prevention education; $129K for middle school; and $75K for high school.

- **Classroom prevention education by law enforcement officers** - the Police Department, Office of the Sheriff, and MCPS together spend $0.7 million to fund staff and supplies for teaching the DARE program to 5th graders.[5] Another $94K in MCPD officer time in spent on the Community Outreach Program (a five-lesson prevention source taught to 7th graders in selected middle schools), and $21K in officer time (from the Alcohol Initiatives Unit) to teach single lessons in 10th grade health classes.

- **Alternative activities** - Approximately $1.5 million is allocated to the Recreation Department, Department of Health and Human Services, Community Use of Public Facilities, non-profit organizations, and community based groups to sponsor a range of structured, safe, and fun activities for teens during peak "at risk" hours. These activities offered throughout the County and open to all teens are considered universal prevention programs.

- Another $1 million of universal prevention activities in public schools is delivered through portions of the Safe and Drug Free Schools Project ($0.4 million) and School Health Services ($0.6 million).

$1.9 million (29%) funded selective prevention programs. Major FY 02 expenditures in this category are:

- **The Drug Elimination Program** ($0.5 million) - For the past decade, this program has provided various ATOD prevention activities to residents of the Housing Opportunities Commission's public housing complexes.[6]

- **The Police Activities League** ($0.3 million) - Staff from the Montgomery County Police Department, M-NCPPC Park Police, and Recreation Department provide this after-schools educational/recreational program for youth ages 7-17; PAL is currently located at Good Hope and Rosemary Hills community centers.

- **Screening Assessment Services for Children and Adolescents (SASCA)** ($0.5 million) - this DHHS program works with juveniles identified by the juvenile justice system as in need of substance abuse education and/or treatment; approximately $250K of SASCA's budget supports selective prevention activities.

- **Student Assistance Program** ($81K) - Funded through the Safe and Drug Free Schools Project, the Student Assistance Program uses prevention interventions to address at-risk behavior of middle and high school students.

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[5] FY 02 DARE program costs are as follows: $653K is for the law enforcement officers who teach DARE ($576K for MCPD officers and $77 for a Deputy Sheriff) and $63 is for instructional supplies (paid for by MCPS in FY 02).

[6] The primary source of funding for HOC's prevention activities has been a Drug Elimination Grant from the federal Department of Housing and Urban Development. As noted above, the federal government is eliminating this grant program.

$0.5 million (8%) funded indicated prevention programs. FY 02 expenditures in this category are:

- **Phoenix I/II** is one of MCPS' alternative programs and is structured for students with substance abuse problems. The FY 02 cost of Phoenix I/II is $558K, of which about half goes to fund selective prevention activities and half to fund indicated prevention activities.

- **Screening Assessment Services for Children and Adolescents** - As indicated above, this DHHS program works with juveniles identified by the juvenile justice system as in need of substance abuse education and/or treatment. Approximately $250K of SASCA's budget supports indicated prevention activities.

2. Spending among the Six Categories of Prevention Strategies

The Center for Substance Abuse Prevention (CSAP) defines six categories of prevention strategies:

Information dissemination is designed to increase knowledge and alter attitudes about issues related to alcohol, tobacco, and other drug use and abuse. Examples: alcohol and drug information centers; newsletters and brochures; speaking engagements; health fairs; radio and TV public service announcements.

Prevention education provides instruction about alcohol and drug use, abuse and addiction, and teaches participants critical personal and social skills that promote health and well being among youths and help them avoid substance abuse. Examples: classroom-based instruction; training workshops.

Alternative Activities assume that youth who participate in drug-free activities will have important developmental needs met through these activities rather than through drug related activities. Examples: after-school educational and recreational activities; drop-in centers; after-prom parties; drug-free dances and parties.

Problem identification and referral involves recognizing youth who have already tried drugs or developed substance use problems and referring them for assessment, educational programs, and/or treatment. Examples: alcohol and drug hotlines, court diversion programs; the Student Assistance Program.[7]

[7]Across the country, federal Drug-free Schools and Communities funds support local implementation of the Student Assistance Program, which involves identifying students who may be using drugs or alcohol, providing counseling for students who are using drugs or whose poor academic performance place them at risk for substance abuse, and working with parents and community groups to deal with substance abuse problems.

Community-based process enhances community resource involvement in substance abuse prevention by building interagency coalitions and training community members and agencies in substance abuse education and prevention. Examples: public/private community planning groups, task forces, and action teams.

Environmental approaches attempt to promote policies that reduce risk factors and/or increase protective factors related to substance abuse. Examples: drug-free school zones; lobbying to increase taxes on alcohol/tobacco products; billboards/advertising; mass media campaign to decrease student binge drinking.

OLO worked with agency staff to sort the inventory of prevention programs into the six CSAP program strategies. Recognizing that programs often use more than a single strategy, the general rule OLO employed was to sort programs according to the *dominant* strategy employed. In cases where no dominant strategy could be identified, programs were sorted into more than one category and the associated program funds divided accordingly.

Table 9 (page 64) summarizes how the funds appropriated for ATOD prevention across agencies are allocated among the six CSAP prevention strategies. In sum, of the $6.6 million appropriated in FY 02[8]:

$3.1 million (47%) funded prevention education. Major FY 02 expenditures in this category are:

- Classroom prevention education taught by MCPS teachers as part of the health curriculum, Pre-K through 12th grade ($0.7 million);

- The DARE program - classroom prevention education taught by law enforcement officers to 5th graders ($0.7 million);

- Safe and Drug Free School Project prevention education activities ($0.4 million), e.g., The Summer Institute, Character Education, the Elementary Prevention Network;

- Portions of School Health Services ($360K), Screening Assessment Services for Children and Adolescents ($248K), Phoenix I/II ($186K), HOC's Drug Elimination Program ($171K), and the Pre-School Program ($145K).

[8] Similar to the sort among IOM categories, the total amount divided among the six CSAP strategies ($6.6 million) is less than the total $6.7 appropriated because of $108K in administrative costs from MCPS, DHHS, and Department of Recreation that were not attributed to any specific program.

$1.8 million (28%) funded alternative activities. Major FY 02 expenditures in this category are:

- A wide range of Teen Program activities organized and managed by the Recreation Department, including Teen Centers, Teen Clubs, Teen Leadership, Teen After School ($1.03 million);

- Police Activity League programs staffed by Montgomery County police officers, Park Police officers, and Recreation Department staff at the Good Hope and Rosemary Hills community centers ($0.3 million);

- Alternative activities organized by the Housing Opportunities Commission for public housing residents as part of the Drug Elimination Program ($171K); and

- Portions of the Phoenix I/II program ($186K).

$0.9 million (14%) funded programs that include problem identification and referral. Major expenditures in this category are:

- The Student Assistance Program (175K), which is a significant component of MCPS' Safe and Drug Free Schools Project;

- Portions of Screening Assessment Services for Children and Adolescents (248K), School Health Services ($261K), and the Phoenix I/II (186K) programs.

The remaining $0.7 million or 11% of funds funded activities classified as using the other three CSAP prevention strategies as follows:

$360K (5%) funded activities classified as community based process strategies. This includes components of Drawing the Line on Underage Drinking, the Hospitality Resource Panel, the Prevention Network, the HOME program, and other activities of DHHS' health promotion and prevention unit.

$250K (4%) funded information dissemination activities provided as part of various programs, including the Prevention Center, the Students Opposed to Smoking (SOS) program, and Anti-Tobacco Clubs.

$110K (2%) funded activities classified as environmental strategies. In particular, these funds support specific initiatives of the Prevention Center, Drawing the Line on Underage Drinking, and DHHS' health promotion and prevention unit.

TABLE 9
FUNDING BY CENTER FOR SUBSTANCE ABUSE PREVENTION CATEGORIES, FY 02
($ in 000s)

Source of Funds	Information Dissemination	Prevention Education	Alternative Activity	Problem ID and Referral	Community Based Process	Environmental Strategy	Total ($ in 000's)
County	$202	$2,102	$1,601	$548	$165	$109	$4,727
Non-County	$48	$1,038	$250	$373	$195	$1	$1,905
Total	$250	$3,140	$1,851	$921	$360	$110	$6,632*
% of Total Funding	4%	47%	28%	14%	5%	2%	100%

*The total $6.6 million distributed among IOM categories is less that the total $6.7 million identified earlier due to $108K in administrative costs (from MCPS, DHHS, and Recreation Dept.) not attributed to specific programs.

Source: OLO and agency staff, March 2002

C. Inventory of Prevention Programs by Department/Agency

This section presents tables that summarize, by agency/department, the programs included in the inventory of prevention programs. The tables include page references to Appendix A where the reader can find more information on each program, including its stated goals and description of activities, FY 02 budget, staffing level, sources of funds, and performance measures. Where available, the program descriptions in Appendix A also include contain information on how the agencies' FY 03 budget request would change program funding.

Following the tables of prevention programs in the inventory is a list of related programs identified during the course of research for this report. Programs on this list (Table 20, page 72) play an important role in the County's comprehensive approach to increasing protective factors and reducing risk factors, but do not cite preventing alcohol, tobacco, and other drug use among school-age youth as one of their primary goals.

The Inventory

TABLE 10
MONTGOMERY COUNTY PUBLIC SCHOOLS*

Program/Activity	IOM Category	CSAP Category	FY 02 County Funding	FY 02 Non-County Funding	Total	Program Summary in Appendix A
Health Education						
-Elementary school	Universal	Prevention Education	$513,305	$44,440	$557,745	A-4
-Middle school	Universal	Prevention Education	$45,915	$37,944	$83,859	A-4
-High school	Universal	Prevention Education	$64,270	$10,400	$74,670	A-4
Safe & Drug Free Schools Project	Universal	Prevention Education	$64,295	$249,647	$313,942	A-31
Student Assistance Program & staff development courses	Selective	Prevention Education & Identification and Referral		$210,161	$210,161	A-31
Administrative costs				$73,881	$73,881	
Alternative Programs – Phoenix I/II	Selective & Indicated	Alternative Activity, Prevention Education, & Problem Identification and Referral	$550,582	$7,000	$557,582	A-36
Total MCPS			**$1,238,367**	**$633,474**	**$1,871,841**	

*** Additional Budget Information**

(a) The health education costs shown were developed in consultation with MCPS staff and represent estimated costs for teacher time and instructional supplies.

(b) The $44,440 in non-County funds for the elementary school health curriculum is Safe and Drug Free Schools grant money; to avoid double counting, this amount was subtracted from the Safe and Drug Free Schools funding listed below.

(c) DHHS provides MCPS with an additional $45,000 in non-County funds (Cigarette Restitution Funds) to support the middle school health curriculum.

(d) MCPS provides $23,000 of County funds to the Montgomery County Community Partnership's Prevention Center.

TABLE 11
HOUSING OPPORTUNITIES COMMISSION

Program/Activity	IOM Category	CSAP Category	FY 02 County Funding	FY 02 Non-County Funding	Total	Program Summary at ©
Drug Elimination Program	Selective	Prevention Education, Alternative Activity, Community Based Process	$129,700	$384,000	$513,700	A-38
Total HOC			**$129,700**	**$384,000**	**$513,700**	

TABLE 12
MONTGOMERY COUNTY OFFICE OF THE SHERIFF

Program/Activity	IOM Category	CSAP Category	FY 02 County Funding	FY 02 Non-County Funding	Total	Program Summary at ©
Drug Abuse Resistance Education (DARE)	Universal	Prevention Education	$77,000	-	$77,000	A-78
Total Sheriff Department			**$77,000**	**-**	**$77,000**	

TABLE 13
M-NCPPC PARK POLICE

Program/Activity	IOM Category	CSAP Category	FY 02 County Funding	FY 02 Non-County Funding	Total	Program Summary at ©
Police Activities League (PAL)	Selective	Alternative Activity	$34,000	-	$34,000	A-86
HOME	Selective	Alternative Activity	$9,000	-	$9,000	A-40
Total M-NCPPC			**$43,000**	**-**	**$43,000**	

TABLE 14
MONTGOMERY COUNTY POLICE DEPARTMENT*

Program/Activity	IOM Category	CSAP Category	FY 02 County Funding	FY 02 Non-County Funding	Total	Program Summary at ©
Drug Abuse Resistance Education (DARE)	Universal	Prevention Education	$575,738	-	$575,738	A-78
Police Activities League (PAL)	Selective	Alternative Activity	$270,816	$15,000	$285,816	A-86
Community Outreach Program (COP)	Universal	Prevention Education	$94,472	-	$94,472	A-88
Community Outreach Section	Universal	Information Dissemination	$31,341*	-	$31,341	A-90
Alcohol Initiative Unit – 10th Grade Health Class	Universal	Prevention Education	$21,085**	-	$21,085	A-98
HOME (DHHS)	Selective	Prevention Education, Community Based Process	-	$50,431	$50,431	A-52
Total MCPD			**$993,452**	**$65,431**	**$1,058,883**	

Additional Budget Information

(a) The Community Outreach Section costs shown were developed in consultation with Police Department staff and represent 15% of the Section's total budget.

(b) The Alcohol Initiative Unit costs shown represent officer time spent in 10th grade health class and represent 3% of the Unit's total budget.

TABLE 15
COMMUNITY USE OF PUBLIC FACILITIES

Program/Activity	IOM Category	CSAP Category	FY 02 County Funding	FY 02 Non-County Funding	Total	Program Summary at ©
Anti-Tobacco Clubs	Universal	Information Dissemination, Prevention Education, Alternative Activity	$13,500	-	$13,500	A-113
Total Community Use			**$13,500**	**-**	**$13,500**	

TABLE 16
DEPARTMENT OF RECREATION*

Program/Activity	IOM Category	CSAP Category	FY 02 County Funding	FY 02 Non-County Funding	Total	Program Summary at ©
Teen After School	Universal	Alternative Activity	$202,680	$12,000(a)	$214,680	A-103
Teen Center Program	Universal	Alternative Activity	$274,880	-	$274,880	A-105
Teen Events	Universal	Alternative Activity	$123,955	-	$123,955	A-107
Teen Leadership Programs	Universal	Alternative Activity	$120,180	$0(d)	$120,180	A-109
Teen Clubs	Universal	Alternative Activity	$269,680	-	$269,680	A-111
Police Activities League (PAL)	Universal	Alternative Activity	$22,873	-	$22,873	A-86
Misc. Admin			$4,620	-	$4,620	
Total Recreation			$1,018,868	$12,000	**$1,030,868**	

***Additional Budget Information**

(a) $12,000 is from the State Physical Fitness grant, the Teen After School program receives an additional $15,000 from DHHS under the Cigarette Restitution Fund.

(b) Non-county funds through the HotSpot grants (police) while not located in the Teen Team budget, account for an additional $21,000 of program commitments by the Teen Team in FY 2002.

(c) Current grant applications' (ASAP grant) not in the Teen Team budget for FY 2002, $15,000 for additional after school programs are expected to be received in mid-March and will have to be used by June 30, 2002.

(d) DHHS provides Department of Recreation $46,435 for Teen Leadership programs

FY 2002 staff reduction impacts:

(a) July 1, 2001 the Teen Team consisted of 7 Recreation Specialists (100% programmers), 1 Recreation Supervisor (50% program responsibilities-50% team management) and 1 manager. All budgeted program responsibilities were assigned and we were actively researching grants for additional program dollars.

(b) As of January 1, 2002 the Teen Team has been reduced to 5 Recreation Specialists and 1 manager and yet we have acquired over $30,000 (grants) for additional teen programs in FY 2002.

(c) The Teen Center Initiative was frozen January 1, 2002 to save $ for FY 2002. But due to the lack of career staff to implement the remaining programs, we will also have to cut other teen programs. These cuts will include all middle school After Hours (6 sites), High School Friday Nights (4 sites), 2 countywide Under 21 events and any after game parties that have not been scheduled yet.

TABLE 17
DEPARTMENT OF HEALTH AND HUMAN SERVICES – PUBLIC HEALTH SERVICES*

Program/Activity	IOM Category	CSAP Category	FY 02 County Funding	FY 02 Non-County Funding	Total	Program Summary at ©
Prevention Center	Universal	Information Dissemination, Environmental Strategy	$180,819	-	$180,819	A-44
Tech. Assistance, Professional Dev. & Trng	Universal	Information Dissemination, Community Based Process	$63,362	$61,570	$124,932	A-46
Under 21 Grants	Universal	Alternative Activity, Community Based Process	$59,713	$3,000	$62,713	A-48
Students Oppose Smoking	Universal & Selective	Prevention Education, Information Dissemination	$41,979	$30,000	$71,979	A-50
HOME	Selective	Prevention Education, Community Based Process	$41,893	-	$41,893	A-52
Drawing the Line on Underage Alcohol Use	Universal	Community Based Process, Environmental Strategy	$36,500	$2,500	$39,000	A-54
Montgomery County Hospitality Resource Panel	Universal	Community Based Process	$16,070	$5,659	$21,729	A-58
Literature Review	Universal	Information Dissemination	$13,742	$13,500	$27,242	A-60
Prevention Network	Universal	Information Dissemination Community Based Process	$9,593	$5,242	$14,835	A-62
Mini-Grants	Universal	Prevention Education	$3,000	$80,045	$83,045	A-64
The Baobab Tree Project	Selective	Prevention Education, Alternative Activity	$2,065	$30,000	$32,065	A-66
MISSION	Selective	Prevention Education, Alternative Activity	$2,065	$20,000	$22,065	A-68
Neelsville Knights Against Tobacco	Selective	Prevention Education, Alternative Activity	$2,065	$10,000	$12,065	A-70
Pre-School Program	Selective	Prevention Education	$2,000	$141,750	$143,750	A-72
Teen Leadership	Universal	Alternative Activity	-	$46,435	$46,435	A-109
Middle School Health Curriculum	Universal	Prevention Education		45,000	$45,000	A-4
Teen After School	Universal	Alternative Activity		$15,000	$15,000	A-103
Other Costs	-	-	-	$28,644	$23,416	
Total DHHS -Public Health Services			**$474,866**	**$538,345**	**$1,013,211**	

***Additional Budget Information** (a) Teen Leadership is a Department of Recreation program; the $46,435 represents an ADAA grant received by DHHS that was passed on to support this program. (b) The HOME project also received $51,000 of HITDA funds appropriated through the Police Department's budget. (c)The category of "other costs" includes costs for grant administration and program evaluation.

TABLE 18
DEPARTMENT OF HEALTH AND HUMAN SERVICES - CHILDREN, YOUTH, AND FAMILY SERVICES*

Program/Activity	IOM Category	CSAP Category	FY 02 County Funding	FY 02 Non-County Funding	Total	Program Summary at ©
Screening & Assessment Svs. for Children & Adolescents	Selective & Indicated	Prevention Education, Problem Identification & Referral	$370,631	$126,081	$496,712	A-74
School Health Services*	Universal	Prevention Education, Problem Identification & Referral	$357,755	$262,622	$620,377	A-76
Total DHHS-Children, Family and Youth			**$728,386**	**$388,703**	**$1,117,089**	

* The School Health Services costs show were developed in consultation with DHHS staff and represent 4% of the program's total budget.

TABLE 19
RELATED PROGRAMS FOR SCHOOL-AGE YOUTH

Agency/Dept.	Program/Activity	Brief Description
Department of Health and Human Services	Linkages to Learning	Linkages to Learning provides school based health and human services in the form of health, mental health, social and educational support services to school students. The program is primarily funded by DHHS.
Department of Health and Human Services	Children and Youth Community Services	This program supports a range of activities designed to meet the needs of children, youth and families, including the youth service centers. Specific program activities include: crisis intervention/stabilization, anger management groups, social skills groups, grief & loss groups, divorce groups, short-term prevention oriented counseling, parenting classes, youth empowerment programs, tutoring, mentoring, & outdoor therapeutic recreation. These programs target at-risk populations in public schools & in the community and are offered during school hours and during the evenings.
Montgomery County Police Department	Alcohol Initiatives Unit -enforcement of drinking age laws	Officers working in MCPD's Alcohol Unit conduct a range of activities related to the enforcement of the minimum drinking age laws, including: compliance checks, "cops in shops," surveillance operations, and underage party dispersal.
Office of the Board of License Commissioners	Tobacco and Alcohol Sales Enforcement	Alcohol Tobacco Enforcement Specialists conduct compliance checks (using underage buyers) of both tobacco and alcohol sales in retail outlets throughout the County.
Community Use of Public Facilities (CUPF)	After-School Activities Coordinator (ASAC) Initiative	A member of each middle school staff in the County is contracted by CUPF for nine hours per week to coordinate, expand and advertise after school programs. Some of the ASACs' responsibilities include creating an after school activities handbook, forming an advisory committee, maintaining a participation database, and acting as a resource to all club sponsors.
Montgomery County Public Schools, CUPF, and DHHS	After School Youth Services Grant activities	In January 2001, the Collaboration Council was awarded a $1.4 million grant to provide after school programs to improve the child well being measures that are included in the Children's Agenda. The funds were allocated among MCPS ($1 million) CUPF ($225K) and DHHS ($56K). Most of the funds were awarded to private contractors to provide extended day and summer programs. (In January 2002, the Collaboration Council received a Youth Strategies Consolidated grant award of $1.4 million that has a number of components more directly connected to substance abuse prevention; this grant is listed in Chapter VI as a FY 03 budget item.)

VI. FY 03 Agency Budget Requests for Prevention Programs

This chapter summarizes how the agencies' FY 03 budget requests propose changes to the FY 02 inventory and/or funding of ATOD prevention programs for school-age youth. It also identifies expected changes in non-County funds that are not yet incorporated into the agencies' FY 03 budget requests.

Summary

Across agencies, the total FY 03 budget requests (County and non-County funds), plus expected but not yet formally incorporated increases in outside funding for school-age youth prevention programs is $6.58 million. This represents a reduction of $161K (2%) from the $6.74 million allocated in FY 02.

Table 20 (below) compares bottom-line FY 03 budget requests by agency/department for prevention activities to the amounts budgeted in FY 02. A more detailed breakdown of changes in County and non-County funds by agency/department is included in Table 21 at page 78.

TABLE 20
SUMMARY COMPARISON OF FY 02 APPROVED BUDGETS TO FY 03 BUDGET REQUESTS FOR PREVENTION ACTIVITIES
$ in 000's/(reduction)

Agency/Department	FY 02 Approved Budget	FY 03 Budget Request	FY 02 to FY 03 $ Change	FY 02 to FY 03 % Change
Montgomery County Public Schools	$1,871	$2,009	$138	7%
Dept. of Health and Human Services	$2,131	$1,744	($387)	(18%)
Police Department	$1,059	$1,184	$125	12%
Recreation Dept.	$1,031	$1,181	$150	15%
Housing Opportunities Commission	$514	$130	($384)	(75%)
Other*	$134	$141	$7	5%
Collaboration Council – Youth Strategies Grant for After School Activities	-	$190	$190	100%
Total	**$6,740**	**$6,579**	**($161)**	**(2%)**

*Includes Office of the Sheriff, Community Use of Public Facilities, and M-NCPPC Park Police

With a few notable exceptions, the agencies' FY 03 budget requests propose same services funding for the activities included in the FY 02 inventory of prevention programs for school-age youth. Primarily due to increased compensation costs (i.e., increases in pay and benefit costs) and miscellaneous technical budget adjustments, same services budget requests for FY 03 translate into funding increases of 2-15 percent.

In sum, the exceptions to the same services budget approach to prevention are:

- The County Executive's Recommended FY 03 budget shows a reduction of $376,440[1] in County funds for prevention activities. The budget also notes the Executive's expectation that non-County funds can be obtained to make up for some of the reduction in County dollars.

- The Housing Opportunities Commission's Executive Director's recommended FY 03 budget (scheduled for presentation to the Commission in early April) will reflect the loss of the $384,000 federal Drug Elimination Grant, which had supported prevention activities for public housing residents. As of this writing, the Executive Director of HOC is exploring alternatives for making up some of this lost funding in FY 03.

- Montgomery County Public Schools expects to receive an increase in the County's formula allotment of Safe and Drug Free Schools and Communities (SDFS) grant funds. The latest estimate for FY 03 is $686,988, which would represent an increase of $121,358 (21%) over the FY 02 SDFS grant of $565,630.

- In January 2002, the Collaboration Council received an 18-month Youth Strategies Consolidated Grant award of $1,375,000. Out of the total grant award, about $270K (or 20%) is allocated for specific substance abuse prevention activities.

Each of these changes is more fully described below.

Department of Health and Human Services, Public Health Services - $376,440 reduction in County funding for substance abuse prevention activities

The Department of Health and Human Services' (DHHS) FY 03 budget request includes a number of proposed increases and decreases to the Health Promotion and Prevention program in Public Health Services. Table 22 (pages 79-80) provides a program-by-program listing of the Executives' proposed changes in funding for activities of the Health Promotion and Prevention unit that directly concern substance abuse prevention.

[1] The Executive's FY 03 Recommended Budget shows a total reduction of $419,300 from Health Promotion and Prevention. $376,440 of this reduction comes from substance abuse prevention activities and $42,860 comes from activities other than substance abuse prevention. Specifically, the $42,860 reduction relates to changes in funding of three programs: Latino Tobacco Outreach; the Counseling Center, and teen pregnancy prevention activities

As outlined in the table, the FY 03 Recommended Budget reflects a $376,440 decrease in County funding and a $27,481 increase in non-County funding, for a net reduction of $349,959 for substance abuse prevention activities. The following programs are recommended for net DHHS funding increases in FY 03:

- Drawing the Line — Increase of $17,000[2]
- Program Evaluation — Increase of $10,500
- Mini Grants Program — Increase of $1,000

The following programs are recommended for the largest net DHHS funding reductions in FY 03:

- The Prevention Center — Reduction of $180,819
- Under 21 Grants — Reduction of $59,713
- Teen Leadership — Reduction of $46,435
- Students Oppose Smoking — Reduction of $41,979
- Hospitality Resource Panel — Reduction of $16,070
- Literature Review — Reduction of $13,742

The Montgomery County Community Partnership (MCCP) currently holds the contract with DHHS to operate the Prevention Center and conduct a number of the other substance abuse prevention activities proposed for reduction. According to DHHS staff, MCCP has been directed to apply for alternative funding, e.g., Cigarette Restitution Funds. DHHS staff report that the current materials and resources (books, videotapes, and posters) of the Prevention Center will be relocated to the Wheaton Regional Library.

For more information about each of the programs/activities listed above, see Appendix A.

Housing Opportunities Commission - loss of $384,000 Drug Elimination Grant

For the past decade, the Housing Opportunities Commission has provided a variety of selective prevention activities for its public housing residents, e.g., after-school activities, increased security, parenting classes. A Drug Elimination Grant from the federal Department of Housing and Urban Development (HUD) has provided the primary source of funding for these prevention activities.

In FY 02, HOC's approved budget included $514,000 for prevention activities in public housing. The Drug Elimination Grant provided $384K or 75% of the funding, with the balance of $130,000 provided through County funds. A portion of the grant funds were used to pay for extra Montgomery County patrol officer time in selected public housing complexes.

[2] DHHS staff advise that this $17K increase for DTL relates specifically to new FY 03 activities and not to overall program coordination.

The federal government is eliminating the Drug Elimination Grant program later this year, and HOC staff report there are sufficient grant funds to support programming through October 2002. The Executive Director's FY 03 budget (scheduled for presentation to the Housing Opportunities Commission in April 2002) will reflect the loss of the $384,000 in federal funds associated with the termination of this grant program.

HOC's FY 03 budget is expected to maintain (but not increase) the $130,000 in County funds for prevention activities in public housing. As of this writing, the Executive Director of HOC is exploring alternative funding sources to make up at least some of the lost grant funding in FY 03.

Montgomery County Public Schools - Expected increase in Safe and Drug Free Schools grant funds

Montgomery County Public Schools receives federal Safe and Drug Free Schools and Communities Act (SDFS) grant funds through the State Department of Education. The grant amount is calculated annually according to a formula based on enrollment and previous years' awards.

In FY 02, MCPS received $565,630 in SDFS grant funds. Although the exact FY 03 SDFS grant amount will not be known for several months, the latest estimate of $686,988 represents an increase of $121,358 or 21%.

MCPS uses the SDFS grant to fund the Safe and Drug Free Schools Project, which includes a range of prevention activities, including:

- The Student Assistance Program;
- School Community Action Teams;
- Staff training;
- Expenses associated with the elementary school health curriculum;
- Parent and teacher training on substance abuse and violence prevention; and
- The Elementary Prevention Network.[3]

From year to year, increases in SDFS funding are used to enhance one or more of the above prevention activities.

Collaboration Council: Youth Strategies Consolidated Grant

In January 2002, the Collaboration Council received an 18-month grant award of $1.4 million to support a variety of programs, all designed to prevent involvement with or to assist children and youth currently involved with the juvenile justice system or substance abuse. A combination of public and private agencies will deliver the services and the Collaboration Council will maintain oversight, monitoring, evaluation, and reporting responsibilities.

[3]For more information on the Safe and Drug Free Schools Project, see Appendix A, ©31.

Out of the $1.4 million, about $270K is allocated for substance abuse prevention activities. The Collaboration Council's grant overview describes these three allocations as follows:

Drawing the Line on Underage Drinking
$56,250 (September '02-June '03)
Support the DHHS Prevention Office to continue environmental change, norms enforcement and community organizing to reduce ATOD use; this is an add-on for specific projects to be initiated in FY 03.

Parents as the Anti-Drug
$25,000 (Jan '02--June '03)
DHHS Prevention Coordinator to develop collaborative partnerships among public and private groups that target the parents of pre- and adolescent youth with regard to child development and effective communication to identify and utilize culturally responsive, effective curricula and practices.

After School Activities
$190,000 (July '02--June '03)
Through an RFP process, increase the availability of after school activities for middle school students in at-risk communities via public and/or private providers

It is OLO's understanding that the first two grant amounts listed above ($81,250) have been assumed in the Executive Recommended FY 03 Budget for DHHS in the Health Promotion and Prevention unit. As of this writing, the distribution of the $190K for after-school activities to public and/or private providers has yet to be determined.

TABLE 21
COMPARISON OF FY 02 APPROVED BUDGETS TO FY 03 BUDGET REQUESTS FOR PREVENTION ACTIVITIES
$ IN 000'S/(REDUCTION)

Agency/Department	FY 02 Approved Budget			FY 03 Budget Request			FY 02 to FY 03	
	County Funds	Non-County	Total	County Funds	Non-County	Total	$ Change Total Funding FY02 to FY03	% Change Total Funding FY02 to FY 03
Montgomery County Public Schools	$1,238	$633	**$1,871**	$1,222	$787	**$2,009**	$138	7%
Housing Opportunities Commission	$130	$384	**$514**	$130	$0	**$130**	($384)	(75%)
M-NCPPC - Park Police	$43	$0	**$43**	$45	$0	**$45**	$2	5%
Office of the Sheriff	$77	$0	**$77**	$82	$0	**$82**	$5	6%
County Government								
Health & Human Services								
• Public Health Services	$476	$538	**$1,014**	$98	$506	**$604**	($410)	(40%)
• Children, Youth, and Family Services	$728	$389	**$1,117**	$737	$403	**$1,140**	$23	2%
Police Department	$993	$66	**$1,059**	$1,118	$66	**$1,184**	$125	12%
Recreation Department	$1,019	$12	**$1,031**	$1,169	$12	**$1,181**	$150	15%
Community Use of Public Facilities	$14	$0	**$14**	$14	$0	**$14**	$0	0%
Collaboration Council – Youth Strategies Grant for After School Activities	-	-	-	$0	$190	**$190**	$190	0%
Total	**$4,718**	**$2,022**	**$6,740**	**$4,615**	**$1,964**	**$6,579**	**($161)**	**(2%)**

TABLE 22

DETAILED BREAKDOWN OF FY 02APPROVED BUDGET TO FY 03 BUDGET REQUEST BY ACTIVITY, DEPARTMENT OF HEALTH AND HUMAN SERVICES, HEALTH PROMOTION AND PREVENTION SECTION (REDUCTIONS IN PARENTHESIS)

VII. Activity	FY 02 Approved Budget			FY 03 Budget Request			FY 02 - FY 03 $ Difference		Net Change Proposed for FY 03
	County $	Non-County $	Total $	County $	Non-County $	Total $	County $	Non-County $	
Prevention Center	$180,819	$0	$180,819	$0	$0	$0	($180,819)	-	($180,819)
Under 21 Grants	$59,713	$3,000	$62,713	$0	$3,000	$3,000	($59,713)	$0	($59,713)
Teen Leadership	$0	$46,435	$46,435	$0	$0	$0	$0	($46,435)	($46,435)
Student Oppose Smoking	$41,979	$30,000	$71,979	$0	$30,000	$30,000	($41,979)	$0	($41,979)
Drawing the Line	$36,500	$2,500	$39,000	$0	$56,000	$56,000	($36,500)	$53,500	$17,000
Hospitality Resource Panel	$16,070	$5,659	$21,729	$0	$5,659	$5,659	($16,070)	$0	($16,070)
Technical Assistance	$63,362	$61,570	$124,932	$49,533	$73,070	$122,603	($13,829)	$11,500	($2,329)
Literature Review	$13,742	$13,500	$27,242	$0	$13,500	$13,500	($13,742)	$0	($13,742)

Table 22 is continued on the next page.

TABLE 22 CONTINUED

Activity	FY 02 Funding			Recommended FY 03 Funding			Net $ difference		Total
	County $	Non-County $	Total $	County $	Non-County $	Total $	County $	Non-County $	
Prevention Network	$9,593	$5,242	$14,835	$0	$7,187	$7,187	($9,593)	1,945	($7,648)
Neelsville Knights	$2,065	$10,000	$12,065	$0	$10,000	$10,000	($2,065)	$0	($2,065)
The Baobab Tree Project	$2,065	$30,000	$32,065	$0	$30,000	$30,000	($2,065)	$0	($2,065)
Mission	$2,065	$20,000	$22,065	$0	$20,000	$20,000	($2,065)	$0	($2,065)
Mini-Grants	$3,000	$80,045	$83,045	$4,000	$80,045	$84,045	$1,000	$0	$1,000
Pre-School Program	$3,000	$141,750	$144,750	$3,000	$141,750	$144,750	$0	$0	$0
HOME	$41,893	$0	$41,893	$41,893	$0	$41,893	$0	$0	$0
Indirect Costs	$0	$5,228	$5,228	$0	$1,699	$1,699	$0	($3,529)	($3,529)
Middle School Health Curriculum	$0	$45,000	$45,000	$0	$45,000*	$45,000	$0	$0	$0
Teen After School	$0	$15,000	$15,000	$0	$15,000*	$15,000	$0	$0	$0
Program Evaluation	$0	$0	$0	$0	$10,500	$10,500	$0	$10,500	$10,500
Other Costs	$0	$23,416	$23,416	$0	$23,416	$23,416	$0	$0	$0
Total	$474,866	$538,345	$1,013,211	$98,426	$565,826	$664,256	($376, 440)	$27,481	$349,959

*Assumes no changes to Cigarette Restitution Funding.

VII. Measuring the Performance of Prevention Programs in the County

This chapter reviews the role of the Maryland Adolescent Survey in measuring the effectiveness of the County's ATOD prevention programs and summarizes the performance measures currently collected and reported.

A. The Role of the Maryland Adolescent Survey in Measuring Results

Every two years, as reviewed in Chapter II, the State Department of Education administers the Maryland Adolescent Survey (MAS) to 6th, 8th, 10th, and 12th graders throughout the State. The MAS produces a wealth of self-reported survey data on the use of alcohol, tobacco, and other drugs by MCPS students.[1]

MAS results provide trend data on the self-reported rates of alcohol, tobacco, and drug use among the County's school-age youth.[2] The MAS data provide valuable information for answering questions such as:

- What percentage of MCPS students are using alcohol, cigarettes, marijuana, and/or other drugs?
- With what frequency are MCPS students using these substances?
- How do the use rates reported today compare to those reported in previous years?
- How do use rates in Montgomery County compare to rates reported State and nationwide?

The County is fortunate to have the MAS data available to answer these critical questions. **However, a measurable cause-and-effect link between the County's investment in specific prevention activities and the substance use behavior of the County's youth cannot be proved using the MAS.**

B. Performance Measures Collected and Reported

For the most part, the agencies conducting the programs included in this IBR study, collect, track, and report activity or workload data. In some cases, they also collect immediate results data.

Similar to the great majority of prevention programs across the country, the design and implementation of most Montgomery County prevention programs do not allow for the measurement of longer-term program outcomes or results. In other words, the programs do not include the necessary control group(s) or data collection mechanisms needed to evaluate a program's validity or reliability.

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[1] MAS data are available for the County as a whole, but not on any level below that, e.g., school-by-school or cluster level data are not available.

[2] For more on the specifics of the MAS methodology, see Appendix E.

An exception to this is MCPS's evaluation of two middle-school classroom prevention education programs that is currently underway. Specifically, MCPS will collect data that, over time, will allow a reliable assessment of how Project ALERT and Project TNT programs affect participants' rates of substance use. This effort is also notable because these two programs are rated as model programs by the federal Center for Substance Abuse Prevention.

In addition, MCPS' Safe and Drug Free Schools (SDFS) Project is federally mandated to be based upon the federal Department of Education's four "Principles of Effectiveness," which include a thorough needs assessment, measurable goals and objectives, research-based programs, and frequent program evaluation. The Maryland State Department of Education recently commended MCPS' Safe and Drug Free Schools Project for adhering to these four Principles of Effectiveness.

The rest of this chapter provides examples of the performance measures collected and reported by programs in each of the six prevention strategies identified by the Center for Substance Abuse Prevention.

a. Performance Measures for Information Dissemination Programs

The County programs that cite information dissemination as a dominant prevention strategy generally measure their performance by comparing their actual activities to their pre-established target goals. Examples:

The Department of Health and Human Services' Health Prevention and Promotion program tracks and reports the number of literature reviews conducted and the number of individuals on the distribution list for their monthly substance abuse literature review. In FY 01, for example, DHHS completed 10 literature reviews and distributed each review to 600 individuals.

The Prevention Center establishes annual information dissemination targets for items such as: the number of newsletters produced, flyers distributed, videos/books loaned, etc. Each year, staff track and report on the number of actual outputs against that year's performance target. The following table lists some of the Prevention Center's FY 01 information dissemination target and actual outputs.

TABLE 23
THE PREVENTION CENTER'S INFORMATION DISSEMINATION OUTPUT TARGETS AND ACHIEVEMENTS

Information Disseminated	Target Output for FY 01	Actual Output Achieved in FY 01
Quarterly Newsletters produced	4	4
Flyers distributed	2,000	2,000
Response to telephone inquiries	540 calls/year	606 calls/year
Videos/books loaned	110 videos/month 50 books/month	147 videos/month 51 books/month

Source: The Prevention Center, February 2002

b. Performance Measures for Prevention Education Programs

Staff of prevention education programs report that they measure performance by collecting data on: who participates, the performance of the facilitator/teacher, and the immediate impact of the prevention education program on participants' knowledge about and attitudes towards substance use. Examples:

The Safe and Drug Free Schools Project collects data on the number and description of individuals who participate in the annual Summer Institute Conference. In FY 01, for example, 410 participants representing various public and private organizations attended the Summer Institute.

The Pre-School Program collects data on the number of pre-school children and adults who attend summer, fall, and spring sessions. During the 2000-2001 school year, for example, 89 adults and 73 pre-schoolers attended the summer program sessions; 63 adults and 73 pre-schoolers attended the fall program sessions; and 109 adults and 104 pre-schoolers attended the spring program sessions.

After each annual **Character Education Summit** (coordinated by the Safe and Drug Free Schools Project), participants are asked to complete a written survey to indicate if the Conference achieved its goals. Participants are also asked to list which workshops/sessions were the most useful and to rate the program presenters.

The **DARE** program measures changes in students' knowledge of subjects covered in the DARE curriculum by giving students a pre- and post knowledge test. A State of Maryland DARE 2000-2001 Annual Report reports that students in Montgomery County had an average 21 point increase (out of a 100 point scale) in their knowledge of DARE subjects after participating in the DARE program.

As noted at the beginning of this chapter, MCPS is just now implementing a more rigorous impact evaluation of two middle school classroom prevention education programs - **Project ALERT and Project TNT**.

c. Performance Measures for Alternative Activities

Agency staff report that performance data for alternative activities are typically the number/type of activities and number of participants. Some programs also collect data related to the short-term impact of the activity. Examples:

The **Department of Recreation's various Teen Programs** track and report the number of activities and number of program participants. For example, Teen Clubs report there are 35 active clubs with current registration of more than 5,000 teens; the Teen Events program reports on attendance at the 18 events planned for FY 02; the Teen Leadership program reports the Counselor-in-Training program trained 600 teens last summer and that the Kids Enjoy Exercise Now program paired 25 volunteer teens with disabled teens.

The **Police Activity League** (PAL) program reports on the numbers of students enrolled. This year, for example, PAL staff work with an average of 45-50 students every afternoon at the Good Hope Community Center.

HOC's **Drug Elimination Program** reports twice a year on both program activity levels and immediate results. The program collects data on the number of participating youth and other family members in activities offered. Program staff also collect short-term results information, such as changes in the report cards of youth participating in homework clubs and participant surveys about knowledge gained.

The Community Use of Public Facilities' **Anti-Tobacco Program** collects data on the number of students who regularly participate in each club and the number of hours each Club met during the school year. During the 2000-2001 school year, for example, an average of eight students regularly participated in each of the Anti-Tobacco Clubs, and each Club met an average of 40 hours during the school year.

d. Performance Measures for Programs that do Problem Identification and Referral

Programs that use the problem identification and referral strategy generally report the number of youth involved, and in some cases, the immediate results of the intervention. Examples:

DHHS' **Screening Assessment Services for Children and Adolescents** (SASCA) program tracks the number of youth participants and the percentage of those successfully diverted to prevention education and/or outpatient treatment programs. SASCA defines a successful diversion as the confirmation that a youth diverted to prevention education/treatment has begun or completed the program. For example, SASCA reports that the percentage of youth successfully diverted to a prevention education/treatment program was 75% in FY 00 and 69% in FY 01.

The **Student Assistance Program** (part of MCPS' Safe and Drug Free Schools Project) tracks the number, grade, and gender of student referrals that Student Assistance Teams follow-up. The Student Assistance Program also tracks the number of treatment interventions for middle and high school students. MCPS includes data on the Student Assistance Program in the semi-annual SAFE (School Accountability Funding for Excellence) progress report required by the State Department of Education.

Note: MCPS' Student Assistance Program was one of four Student Assistance Programs in Maryland that volunteered to participate in a pilot study (conducted by the University of Maryland's Center for Substance Abuse Research) determine the feasibility of a statewide Student Assistance Program evaluation and to determine the outcome of Student Assistance Program interventions in participating schools. Highlights of the study (completed in January 2002) included that: overall, parents were pleased with their treatment by MSAP staff; however, not all parents followed the schools' recommendations to get their children assessed and some parents felt their children did not need assessment. CESAR also concluded that a statewide evaluation of Student Assistance Programs is feasible.

e. Performance Measures for Community Based Process Programs

The performance of programs that use the community-based process strategy track performance primarily by the number of meetings attended or events held throughout the year.

For example, during FY 02, the **Hospitality Resource Panel** reports holding two networking meetings, ten issue forums, four task force meetings, and two owner-manager training seminars. During FY 02, the **Prevention Network** reports holding six meeting that were each attended by an average of 20-25 participants.

f. Performance Measures for Environmental Strategies

Two prevention programs funded in FY 02 use environmental strategies: Drawing the Line on Underage Drinking and the Prevention Center.

Drawing the Line on Underage Drinking (DTL) tracks the number of meetings held, and the various projects/activities sponsored. This year, for example, DTL reports holding monthly meetings with its partners, distributing magnets during prom season, observing court proceedings, and awarding about $80K in mini-grants to public and non-profit organizations for community based prevention efforts that focus on parenting and mentoring.

The Prevention Center reports hosting a monthly task force meeting on mentoring in Montgomery County, a monthly Smoke Free Montgomery meeting, and a monthly Prevention Network meeting.

VIII. Results of the Inter-Agency Worksessions

The design of this IBR project included three facilitated worksessions among key representatives from County-funded agencies currently engaged in ATOD prevention activities for school-age youth. OLO invited the Montgomery County Public Schools, Montgomery County Council of PTAs, County Government Departments of Health and Human Services, Police, and Recreation, Community Use of Public Facilities, Collaboration Council, and the Housing Opportunities Commission to send a mix of senior management and front-line practitioners to the worksessions. (See Appendix P for a list of meeting participants.)

The purpose of the three worksessions was to:

- Solicit agency views on current alcohol, tobacco, and other drug prevention activities that target school-age youth (pre-K through 12th grade) in Montgomery County;

- Identify where County practitioners and managers agree and disagree on current and potential ATOD prevention strategies for this age group; and

- Help OLO/Council staff develop recommendations to the Council on setting priorities for funding ATOD prevention activities for school age youth in the FY 03 operating budget.

The agenda consisted of the following five discussion questions:

Issue #1: What are the strengths and weaknesses of the County's ATOD prevention activities? Which strategies/practices are "working" and which are "falling short"?

Issue #2: How is the effectiveness of ATOD prevention efforts currently measured and reported? How should the effectiveness of these efforts be measured and reported?

Issue #3: If resources were not a constraint, what should County-funded agencies be doing either differently or in addition to current efforts to be more effective in our ATOD prevention efforts that target school-age youth?

Issue #4: How are ATOD prevention activities among the different agencies currently coordinated? Who speaks to whom, about what, how often? How are problems solved, decisions made, critical information shared? In what ways could/should this coordination be improved? (How would we know it when we arrive at the right level of coordination?)

Issue #5: Given the County's current fiscal situation, what should the Council establish as the top five ATOD prevention activities to fund in FY 03? Why?

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SCHOOL-AGE ATOD PREVENTION PROGRAMS

The Practitioner/Administrator Worksessions

In February, 2002, the Montgomery County Office of Legislative Oversight convened three worksessions in which staff and management involved with school-age ATOD prevention assessed existing school-age programs and activities. The exercise was part of a Council-assigned Intensive Budget Review project.

The structure and format

The worksessions were each two hours in length and were conducted by a professional moderator. Each session was structured around a set of specific agenda items:

- In the first session, the participants were asked to identify which County ATOD prevention programs and practices are having their intended impact and which are inadequate or ineffective. The group was also asked to discuss how the efficacy of these programs is currently measured.
- The first part of the second session focused on the coordination of current prevention initiatives across programs and agencies. The group was asked to discuss how information is shared, how problems are solved and decisions made, where there are instances of inter-program collaboration, and so forth. In this meeting's second half, the group made a first stab at FY03 recommendations.
- The final session was devoted to refining the recommendations. These ended up being broad and process oriented. As a result, the group spent some time identifying the obstacles that prevented it from rendering more concrete, program-specific budget priorities.

The recommendations

The group agreed on three, formal recommendations:

1 **Raise the level of ATOD prevention planning, coordination, and oversight to a single, senior policy level group. This collaborative group should include, for example, County Government Department heads, high-level MCPS, HOC, and other agency staff, and a Council representative.**

2 **Pool existing agency resources to evaluate the effectiveness of County (and other established) ATOD prevention programs and activities. This comprehensive, coordinated evaluation should:**

- **Begin with an in-depth review of existing research and County data;**
- **Serve as a basis for program planning, priority setting, and resource allocation;**
- **Serve as a basis for the development of a system of data collection, management, and analysis;**
- **Produce a series of additional recommendations in areas such as staffing, staff development, community outreach, and so forth;**
- **Inaugurate a permanent practice of ongoing, joint program evaluation.**

3 **Maintain FY02 funding levels for all current ATOD prevention programs and activities until after Recommendations #1 and #2 are implemented. The structures and processes outlined in these recommendations will position the County to make far more informed cost-benefit analyses and program funding decisions.**

The challenges

For at three reasons, the task of placing specific County programs in priority order proved to be enormously challenging. Ultimately in fact, the group acknowledged that it did not – and perhaps could not – provide program-specific budget recommendations for the Council.

1 Many participants were unfamiliar with the full array of County ATOD prevention programs. Others, while generally aware, had minimal knowledge of other programs' specific approaches, populations, budgets, and performance. This fact alone made a consensus ranking of programs practically impossible for the group to produce.

2 While many participants knew that a sizable body of national research exists on ATOD prevention practices targeting school age youth – and some make an ongoing study of this literature – the group acknowledged that its collective familiarity with research trends and findings was far from in-depth. This made it untenable (in the six hours allotted) to draw intelligently on the available research to place the County's programs and activities in a priority order.

3 Most attendees noted as evidence of effectiveness the correlation between favorable County trends on the Maryland Adolescent Survey and the amalgam of prevention programs and activities in this jurisdiction. Given the commonly accepted premise that ATOD initiatives have the greatest impact when they address their targets in multiple ways from multiple angles at multiple times, it is entirely reasonable to regard this correlation as an indicator of general effectiveness. Indeed, we probably would not hesitate to find these programs culpable were the Survey trends disturbing. Ranking *specific* programs in terms of their *distinct* impact to assure the greatest bang for each budget dollar, however, would have been an exercise in unevenly informed guesswork for the group.

A number of practitioners explained that their measures of effectiveness come in the form of "momentary indices" and individual student testimonials – for example, the gratitude expressed by a pre-teen for time taken and lessons learned; the appreciative memory reported by a high schooler of an earlier, life-changing experience with the practitioner; the fortified resistance to temptation proudly communicated by an at-risk adolescent. In a society that worships neatly organized statistical and longitudinal facts, these idiosyncratic data are easily dismissed as uncontrolled and unrepresentative. It should not be forgotten that, for the practicing educator and clinician, these moments are compelling, valid, and necessary measures of effectiveness. On the other hand, such individualized indicators cannot substitute for systematically collected, program-level outcome data and therefore could not advance the group toward a consensus comparison of ATOD programs.

In sum, data collection and outcome evaluation have simply not been major, uniform priorities for the County's programs. A number of interim, intermediate measures are applied by some activities (e.g., prom deaths due to alcohol, suspensions, student and teacher evaluations, compliance rates), but a comprehensive, coordinated data collection and effectiveness evaluation strategy does not exist today. According to participants, this systemic gap is attributable to: (1) time and service pressures; (2) budgets dedicated to program delivery rather than evaluation; (3) legal restrictions on data collection; and (4) insufficient staff expertise in research methodology.

It should be emphasized that the participants were not identical in their program awareness, data sophistication, research conversancy, or willingness to address the program ranking task "head on." Indeed, there was considerable variability in these respects. But the goal was to achieve a general *consensus* on the programs that have the greatest promise. The deliverable, after all, was supposed to represent a *collective* perspective on the best prevention programs for school age youth in Montgomery County. In the end then, the greater knowledge or relative fortitude of a few could not advance the group as a whole.

Other Outcomes

Given these challenges, some of the worksessions' outcomes are not surprising. For example, when asked which programs and activities seem to be working most effectively, the group ended up listing almost every program in the County (not because the collective belief was that all programs are working equally well, but because the group had no established way to discriminate among them).

When discussing County-wide weaknesses, the group pointed to many of the things that made the worksessions themselves difficult:

- Data and program evaluation insufficiencies;

- Information and communication "disconnects" across programs and agencies, including disconnects between school clusters and ATOD resources potentially available to them;
- The absence of a senior level, politically influential official or group of officials to to assure maintenance of effort and spearhead high profile ATOD prevention efforts, similar to what was done in the County in the late 1980s and early 1990s;
- The failure to use available research as a basis for local program design, implementation, and assessment.

The group also reported the County's deficiencies in:

- Reaching parents, families, and communities with information about ATOD risks, County programs, and the concept of parent accountability;
- Focusing educational and interventional efforts on the County's sizable Middle School population;
- Seeking the input of school age youth (the target population) in the development and refinement of programs designed for their safety and welfare.

Given the group's assertion that joint efforts across programs and agencies have not been what they should be, it was able to list a remarkable number of inter-agency groups, networks, councils, partnerships, advisory bodies, and collaborations. Apparently these were formed during different eras, to fulfill different roles, involving representatives from different organizational levels from different agencies, government-affiliated entities, and community groups. These entities are described elsewhere in this report. Suffice it to say here that, while many of them may be serving productive functions in specific ways, none – according to participants – appears to be serving an overarching, spearheading function. Indeed, it is this function that the group strongly agreed would be the single most important for the continuing development, refinement, coordination, and evaluation of ATOD prevention programs in Montgomery County.

Douglas D. Katz
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20 February 2002

IX. Findings

Introduction

During the past 20 years, Montgomery County has shown a strong commitment to addressing substance abuse issues. Significant staff effort and substantial funds have been allocated to programs and activities aimed at preventing the County's youth from using alcohol, tobacco, and other drugs (ATOD).

Background: Between the late 1970's and the early 1990's, the Montgomery County Government convened a number of task forces and committees to address the County's substance abuse problems. These efforts resulted in several high-profile reports that offered recommendations for improving the County's response to drug and alcohol abuse.

Many of the recommendations are now part of the County's approach to the prevention and treatment of substance abuse. A number of inter-agency groups that operate today evolved from the County's focus on drug and alcohol abuse in the early 1990's.

Alcohol, tobacco, and drug use among Montgomery County Public Schools' students, as among students State and nationwide, peaked in the mid-1990's. Between 1998 and 2001, alcohol and cigarette use by MCPS students declined, in some age cohorts by more than 10 percentage points. While recognizing that progress has been made, 2001 survey data show significant numbers of high school students in the County drink alcohol, smoke cigarettes, and use marijuana.

In recent years, public attention paid to issues of substance abuse and related prevention activities in the County has assumed a lower profile than during the first half of the 1990's. Some attribute this shift to the fact that substance use rates are generally lower; others attribute it to the fact that the nature of the County's drug problem has grown less visible, i.e., the County essentially eliminated its open-air drug markets.

Current Inventory of Programs. This IBR project compiled an inventory of more than 30 County programs that cite ATOD prevention among the County's school-age youth as a primary goal. These programs are administered by the Montgomery County Public Schools, four County Government departments, and three other County-funded agencies (Housing Opportunities Commission, Office of the Sheriff, M-NCPPC). For some of these programs, substance abuse prevention activities account for almost all of their funding; for others, prevention activities represent only one of several program components.

In FY 02, the Council appropriated or approved the spending of $6.7 million[1] to support these ATOD prevention programs/activities; $4.7 million (70%) of this money came from County funds and the other $2 million (30%) came from non-County funds, primarily state and federal grants.

With several notable exceptions, the agencies' FY 03 budget requests propose same services funding for ATOD prevention activities. When combined across the agencies, the proposed changes (increases and decreases) would result in a net reduction of $160K (2%) in funding for prevention activities for school-age youth.

Overview of Program Effectiveness. Much research has been conducted during the past 20 years about what makes for effective substance abuse prevention programs. Model programs proven effective by scientific research are now identified for many (although not yet all) types of prevention strategies.

The current alcohol, tobacco, and other drug (ATOD) prevention activities in the County generally fit within the six prevention strategies identified by the federal government's Center for Substance Abuse Prevention: information dissemination; prevention education; alternative activities; problem identification and referral; community-based process; and environmental approaches.

Only two of the current prevention programs in the County represent local implementation of prevention programs for which there is strong empirical evidence of effectiveness. The two programs are Project ALERT and Project TNT, which were both adopted by MCPS four years ago as part of the middle school health curriculum. For both of these programs science-based research found measurable, positive effects (i.e., to delay, reduce, or prevent altogether) on participants' use of alcohol, tobacco, and/or other drugs.

It is tempting to conclude that reported declines in alcohol and tobacco use among County youth students in recent years result directly from the County's investment in prevention programs. However, here as in communities across the country, the data do not exist to quantify a cause-and-effect link between specific ATOD prevention activities and ATOD use rates in the County.

Results of Inter-Agency Worksessions. As part of this IBR project, OLO convened three facilitated worksessions that included staff representatives from the different departments and agencies involved with ATOD prevention. The results of the worksessions evidence both a desire and need for improved communication and coordination among those involved with ATOD prevention and a strong interest in making decisions based upon knowledge of what is and what is not effective.

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[1] Technically, the Council appropriated all of the FY 02 funds under discussion except for the Drug Elimination Grant ($384K), which the Housing Opportunities Commission received directly from the federal government. While these grant funds were included in the full HOC budget that was reviewed and approved by the Council, Council appropriation of these grant funds is not legally required.

The rest of this chapter summarizes OLO's findings in categories that generally parallel the organization of the overall report.

THE USE OF ALCOHOL, TOBACCO, AND OTHER DRUGS BY SCHOOL-AGE YOUTH

Finding #1: Alcohol is the illegal substance most commonly used by school-age youth. Among MCPS students, marijuana is the second most commonly used substance, with cigarettes coming in third.

Of the MCPS 12th graders surveyed in 2001, 66% self-report having ever tried some form of alcohol; 44% drank during the last 30 days; and 28% had five or more servings of alcohol on the same occasion during the past 30 days.

Of MCPS students surveyed in 2001, 22% of 12th graders, 16% of 10th graders, and 7% of 8th graders self-report the use of marijuana during the last 30 days. With respect to tobacco use, 21% of 12th graders, 11% of 10th graders, and 6% of 8th graders self-report smoking cigarettes during the last 30 days.

Regular use of illegal substances by MCPS students other than alcohol, marijuana, and cigarettes remains relatively low. For example, of 12th grade MCPS students surveyed in 2001, 1.6% self-report use of designer drugs in the past 30 days, 3.2% report use of amphetamines, 1.2% report use of LSD, and 0% report use of cocaine in the past 30 days.

Finding #2: During the past decade, alcohol, tobacco, and other drug use among MCPS students peaked in the mid-1990's. Between 1998 and 2001, alcohol and cigarette use declined in the County, but the use of marijuana and other drugs showed little change.

Between 1998 and 2001, the self-reported use of alcohol and cigarettes by youth declined across the country. The declines reported in Montgomery County generally exceeded those reported State and nationwide.

- The percentages of MCPS 12th graders who report using alcohol in the past 30 days declined from 50% in 1998 to 44% in 2001; among MCPS 10th graders, the percentage dropped from 39% in 1998 to 27% in 2001.

- The percentages of MCPS 12th graders who report using cigarettes in the past 30 days declined from 28% in 1998 to 21% in 2001; among MCPS 10th graders, the percentage dropped from 23% in 1998 to 11% in 2001.

Between 1998 and 2001, the self-reported use of marijuana and other drugs by youth across the country showed little change. The pattern of substance use reported in Montgomery County paralleled this State and nationwide trend.

Finding #3: Across all age categories, the rates of alcohol and cigarette use reported by MCPS students remain at or below the rates reported State and nationwide.

Survey data for 1994, 1996, 1998, and 2001 show that the self-reported use of alcohol and tobacco by MCPS students has generally been below the percentages reported State and nationwide. The differences have been as small as one tenth of a percentage point and as large as 13 percentage points. In 2001, for example:

- 44% of MCPS 12th graders reported drinking alcohol within the past 30 days compared to 48% of 12th graders Statewide and 50% of 12th graders nationwide;

- 21% of MCPS 12th graders report smoking cigarettes within the past 30 days compared to 26% of 12th graders Statewide and 30% of 12th graders nationwide.

Since 1994, the self-reported use of marijuana and other drugs (i.e., other than alcohol and tobacco) by MCPS students has been at times above and at times below that reported elsewhere. In 2001, 25.9% of MCPS 12th graders report using marijuana or other drugs within the past 30 days compared to 28.2% of 12th graders Statewide and 25.7% of 12th graders nationwide.

THE RESEARCH

Finding #4: Much research has been conducted during the past 20 years about what constitutes effective substance abuse prevention programs. Model programs supported by science-based evidence of effectiveness have been identified for some, but not yet all, types of prevention strategies.

Substance abuse prevention research systematically and objectively examines the efficacy and effectiveness of prevention programs and policies. In recent years, practitioners have gained access to prevention research findings. At least four federal agencies actively disseminate information on science-based prevention:

- Center for Substance Abuse Prevention (CSAP);
- National Institute on Drug Abuse (NIDA);
- Office of Juvenile Justice and Delinquency Prevention (OJJDP); and
- U.S. Department of Education.

The Center for Substance Abuse Prevention maintains a National Registry of Effective Prevention Programs. The Registry lists model programs that have produced a consistent pattern of positive results in multiple locations and across multiple target populations, with consideration for age, gender, race/ethnicity, and geographic context.

The Registry labels programs according to the Institute of Medicine's three categories of prevention programming: universal, selective, and indicated. The Registry currently lists numerous model programs for prevention education delivered inside and/or outside the classroom. An increasing number of model programs combine prevention education with other types of prevention strategies, e.g., alternative activities, problem identification/referral, community based process, and environmental approaches.

Finding #5: Multiple interventions across multiple domains increase the chances of overall positive outcomes.

Prevention research has focused on risk and protective factors. **Risk factors** increase an individual or group's vulnerability to substance abuse while **protective factors** build resiliency and increase the likelihood that an individual or group will successfully resist substance abuse. Effective prevention strategies address the risk and protective factors that exist in different domains of a person's life, e.g., individual, peer, family, school, community, workplace, and society. What happens in one domain affects events in the other domains.

Research findings demonstrate that some programs work to delay, reduce, and/or prevent the use of alcohol, tobacco, and other drugs; some programs do not work; some are promising (although not proven) and others have not been tested adequately. Other consistent themes in the research on prevention aimed at school-age youth are:

- No single prevention program is the "best" and no one program will stop all drug use;
- The chances of positive outcome are increased if prevention programs influence young people across multiple domains of their lives, e.g., at school, at after-school activities, at home, in the community; and
- The best approach to substance abuse prevention begins early to reduce emerging behavioral and emotional problems.

Finding #6: Effective school-based prevention programs must go beyond the knowledge-only approach.

The research has found that successful school-based prevention efforts should begin early and continue through adolescence when young people face more immediate pressures to drink, smoke, and use other drugs. Without reinforcement or "booster" sessions, the impact of prevention programs on actual drug use behavior is greatly reduced.

In order to go beyond the knowledge-only approach school-based drug prevention programs should:

- Help students recognize internal pressures such as anxiety and stress, and external pressures such as peer attitudes and advertising, that influence their use alcohol, tobacco, and other drugs.

- Develop students' personal, social, and refusal skills to resist these pressures.

- Use interactive teaching techniques, such as role playing, discussions, brainstorming, and cooperative learning, and

- Actively involve the family and the community.

Finding #7: Published research exists for three of the classroom-based prevention programs delivered in Montgomery County: Project ALERT, Project Towards No Tobacco (TNT), and DARE.

Project ALERT and Project TNT. Four years ago, MCPS selected Project ALERT and Project TNT to include in the County's middle school health curriculum. Both programs have been rated as model programs by the Center for Substance Abuse Prevention (CSAP) based upon empirical research conducted in multiple locations across the country.[3]

To be rated as CSAP model programs, both ALERT and TNT were evaluated in different settings using pre- and post-tests to show positive results. Research findings were published in more than one scientific or academic journal. In particular, the research found ALERT effective in decreasing pro-drug attitudes and beliefs and in reducing use of marijuana and cigarettes. Project TNT was found effective both in reducing the initiation and use of cigarettes.

Drug Abuse Resistance Education (DARE), the most widely implemented school-based drug prevention program in the United States, is provided by law enforcement officers to most 5th graders in Montgomery County. The research on DARE evidences immediate and short-term (up to two years) positive outcomes in terms of students' resistance skills and attitudes towards drugs. However, the research on the longer-term effects of DARE has found that children who participate in DARE are as likely to use drugs as those who do not participate.

[3] The empirical research on ALERT and TNT was not conducted in Montgomery County.

Over the years, DARE's curriculum has been revised several times. A concerted effort is currently underway at the national level to improve the program's effectiveness. A new DARE program is in the process of being developed and tested in pilot sites across the country. Reportedly, DARE's focus will shift from 5th grade to 7th grade students, and add a booster program in 9th grade. In addition, the new program will be more interactive, with students doing more role-playing on how to make decisions. With the DARE curriculum now in transition, it is premature to judge the program's future effectiveness.

Note on published research re: Student Assistance Program. Student Assistance Programs are school-based interventions that provide support for students with various problems, including drug and alcohol abuse. Student Assistance Programs are one of the most common intervention programs in the country, largely because they are funded through federal Safe and Drug Free Schools and Communities funds (SDFS). In Montgomery County, the Student Assistance Program is one of the largest programs within MCPS' Safe and Drug Free Schools Project. Because Student Assistance Program models vary, conducting effective nationwide evaluations has proven difficult. However, several recently published studies have found that fewer students reported using drugs and alcohol after participating in a Student Assistance Program.

Finding #8: When used in conjunction with other prevention strategies, alternative activities can play an important role in reducing alcohol and other drug use.

The research literature contains only limited evaluation findings on alternative activities. As the Center for Substance Abuse Prevention observed in 1996, "Most alternative programs are developed and implemented because they sound like a good idea, not because there is strong research support for a particular approach or even for alternatives in general."

Nonetheless, the general consensus among researchers is that when used in conjunction with other prevention strategies, alternative activities can play an important role in reducing alcohol and other drug use. In addition, alternative programming appears to be most effective among those youth at greatest risk for substance abuse and related problems. The more intensive the program (i.e., greater numbers of hours) the more effective.

Finding #9: Although not science-based, the Center for Substance Abuse Prevention has identified characteristics of "successful" community coalitions.

While the characteristics of a "successful" community coalition can be identified and written about, a reported success in one location cannot be easily replicated in another in the same way that, for example, a classroom education program or mentoring program can be.

Although not based on scientific research, in 1999, the Center for Substance Abuse Prevention published elements of what the agency deemed "successful" coalitions. The characteristics identified included: understanding the community's needs and resources; a widely shared and comprehensive vision; a clear and focused strategic plan; diverse membership (including key community leaders and government officials); strong leadership and committed partners; diversified funding and a well managed staffing structure.

Finding #10: Reducing the physical availability of alcohol and tobacco to minors has been shown to decrease consumption rates among youth.

So-called "environmental strategies" aim to reduce the availability of alcohol and tobacco to minors. Examples are increasing taxes on alcohol and tobacco; restricting the number and location of alcohol outlets; strictly enforcing alcohol age-of-sales laws; and requiring beer keg registration.

A number of research studies have shown that increasing the cost of alcohol by either alcohol taxes or price increases reduces both their purchase and consumption by youth. The same relationship has been shown to exist with increased price and decreased use of tobacco.

FY 02 County Spending on Prevention for School Age Youth

Finding #11: In FY 02, the Council appropriated or approved the spending of $6.7 million for 33 programs/activities that cite ATOD prevention for school-age youth as one of their primary goals.[4]

In FY 02, the $6.7 million for ATOD prevention programs was allocated among multiple agencies/departments as follows:

- $2.1 million (32%) to the Department of Health and Human Services;
- $1.9 million (28%) to Montgomery County Public Schools;
- $1.06 million (16%) to the Police Department;
- $1.03 million (15%) to the Recreation Department; and
- $0.5 million (8%) to the Housing Opportunities Commission.

The remaining $134K (2%) was allocated among three agencies: Office of the Sheriff ($77K); M-NCPPC Park Police ($43K); and Community Use of Public Facilities ($14K).

[4] As noted earlier, technically, the Council appropriated all of the FY 02 funds under discussion except for the Drug Elimination Grant ($384K), which the Housing Opportunities Commission received directly from the federal government. While these grant funds were included in the full HOC budget that was reviewed and approved by the Council, Council appropriation of these grant funds is not legally required.

This IBR project also identified a number of additional programs that support the County's ATOD prevention activities. While these programs each play an important role in the County's comprehensive approach to increasing protective factors and reducing risk factors, their focus is not directed toward preventing alcohol, tobacco, and other drug use. The list of such related programs includes Linkages to Learning, Youth Service Centers, and the County's efforts to enforce alcohol age-of-sales laws.

Finding #12: In FY 02, $4.7 million or 70% of the total amount appropriated for ATOD prevention were County funds and $2.0 million or 30% were non-County funds

State and federal grants make up most of the non-County funds appropriated for ATOD prevention. In FY 02, the largest single outside source of funds was $566K in Safe and Drug Free Schools and Communities Act grant funds provided to MCPS, and the second largest was $490K from the State's Alcohol and Drug Abuse Administration provided to the County's Departments of Health and Human Services and Recreation.

The Cigarette Restitution Fund (CRF) provided close to $400K for ATOD prevention activities in FY 02. The Department of Health and Human Services is the grant recipient of the County's CRF monies; in FY 02, the CRF funds for ATOD prevention were allocated among the County's Department of Health and Human Services and Recreation, and MCPS.

For the past decade, a significant source of outside funding for the Housing Opportunities Commission's ATOD prevention activities has been the Drug Elimination Grant from the federal Department of Housing and Urban Development. The federal government is discontinuing this grant program, which means that as of November 2002, the Drug Elimination Grant ($384K this year) is no longer a potential source of outside revenue.

Finding #13: Almost two thirds of the $6.7 million spent on ATOD prevention programs in FY 02 funded universal prevention programs.

When sorted according to the Institute of Medicine's three categories of prevention programming (universal, selective, and indicated[5]), the $6.7 spent on prevention programs for school-age youth across agencies breaks down as follows:

$4.2 million (63%) funded universal prevention programs. Major expenditures in this category include classroom prevention education by MCPS teachers ($0.7 million); classroom prevention education by law enforcement officers ($0.8); structured, safe, and fun alternative activities for teens during "at risk" hours ($1.5 million); the Safe and Drug Free Schools Project ($0.4 million); and School Health Services ($0.6 million).

[5] In sum, universal programs target a general population; selective programs target specific subgroups whose risk is significantly higher than the general population's; and indicated programs target high-risk individuals who have already substance users. For a more detailed explanation of these three categories, see Appendix C.

$1.9 million (29%) funded selective prevention programs. Major expenditures in this category include the Housing Opportunities Commission's Drug Elimination Program ($0.5 million); the Police Activities League ($0.3 million); DHHS' Screening Assessment Services for Children and Adolescents ($250K); and MCPS' Student Assistance Program ($210K).

$0.5 million (8%) funded indicated prevention programs. Programs in this category are MCPS' Phoenix I/II and DHHS' Screening Assessment Services for Children and Adolescents.

Finding #14: About half of the $6.7 million was allocated for prevention education, a third for alternative activity programs, and ten percent for problem identification and referral.

When sorted according the six categories of prevention strategies identified by the Center for Substance Abuse Prevention, the $6.7 million spent on prevention programs for school-age youth across agencies breaks down as follows:

- $3.1 million (47%) funded prevention education;
- $1.8 million (28%) funded alternative activities; and
- $0.9 million (14%) funded problem identification and referral programs.

The remaining 11% of fund were divided among the other three CSAP prevention categories as follows: $260K (4%) funded information dissemination; $360K (5%) funded community based process; and $110K (2%) funded environmental strategies.

FY 03 Budget Requests for Prevention Activities

Finding #15: With several notable exceptions, the agencies' FY 03 budget requests propose same services funding for substance abuse prevention activities. When combined across the agencies, the proposed changes (increases and decreases) result in a net 2% reduction in funding for prevention activities for school-age youth.

Across agencies, the total FY 03 budget requests (County and non-County funds) for prevention activities is $6.58 million. Behind this macro-number is a series of increases and decreases. Collectively, the $6.58 million is $161K (2%) less than the $6.74 million allocated in FY 02.

With several notable exceptions, the agencies' FY 03 budget requests propose same services funding for the activities included in the FY 02 inventory of prevention programs for school-age youth. Primarily due to increased compensation costs (i.e., increases in pay and benefit costs) and miscellaneous technical budget adjustments, same services budget requests for FY 03 translate into funding increases of 2-15 percent.

In sum, the exceptions to the same services budget approach to prevention are:

- The County Executive's Recommended FY 03 budget for DHHS' Public Health Services shows a net reduction of $376,440 in County funds for prevention activities. The budget notes the Executive's expectation that non-County funds can be obtained to make up for the reduction in County dollars.

  According to DHHS staff, the Executive's Recommended FY 03 budget for Public Health Services would increase and decrease funding for various prevention activities. Programs recommended for net funding increases in FY 03 are Drawing the Line on Underage Drinking; Program Evaluation; and the Mini-Grants Program. Programs recommended for the largest net funding reductions from DHHS are the Prevention Center; Under 21 Grants, Teen Leadership, Students Oppose Smoking, and the Hospitality Resource Panel.

- The Housing Opportunities Commission's Executive Director's recommended FY 03 budget (scheduled for presentation to the Commission in early April) will reflect the loss of the $384,000 federal Drug Elimination Grant, which had supported prevention activities for public housing residents. As of this writing, the Executive Director of HOC is exploring alternatives for making up some of this lost funding in FY 03.

- Montgomery County Public Schools expects to receive an increase in the County's formula allotment of Safe and Drug Free Schools and Communities (SDFS) grant funds. The latest estimate for FY 03 is $686,988, which would represent an increase of $121,358 (21%) over the FY 02 SDFS grant of $565,630.

- In January 2002, the Collaboration Council received an 18-month Youth Strategies Consolidated Grant award of $1,375,000. Out of the total grant award, about $270K (or 20%) is allocated for specific substance abuse prevention activities. Collaboration Council documents describe the funding allocation is as follows:

  Drawing the Line on Under-age Drinking : $56,250 (September '02-June '03)
  Support the DHHS Prevention Office to continue environmental change, norms enforcement and community organizing to reduce ATOD use.

  Parents as the Anti-Drug : $25,000 (Jan '02--June '03)
  DHHS Prevention Coordinator to develop collaborative partnerships among public and private groups that target the parents of pre- and adolescent youth with regard to child development and effective communication to identify and utilize culturally responsive, effective curricula and practices.

  After School Activities: $190,000 (July '02--June '03)
  Through an RFP process, increase the availability of after school activities for middle school students in at-risk communities via public and/or private providers.

  It is OLO's understanding that the first two grants listed above are already incorporated into DHHS' FY 03 budget request. As of this writing, it is yet to be determined which public and/or private providers will receive the after-schools grant funds.

COORDINATION AMONG PREVENTION PROGRAMS IN THE COUNTY

Finding #16: The County has had an appointed Prevention Coordinator, who is part of the State Alcohol and Drug Abuse Administration's Statewide Prevention Network.

The State Alcohol and Drug Abuse Administration (ADAA) manages a Statewide Prevention Network. This Network consists of Prevention Coordinators designated by each of the State's 24 political subdivisions. According to ADAA, the role of each Prevention Coordinator is to communicate with and serve as a community resource for prevention program planning and community building.

ADAA defines the scope of the Prevention Coordinators' responsibilities as broad and based upon the concept of prevention as a life long process. ADAA expects that each Prevention Coordinator will:

> Work closely with all elements of the community including schools, human services agencies, youth services agencies, substance abuse treatment programs, neighborhood organizations, businesses, parent groups, religious groups, and law enforcement officials to identify needs, develop substance abuse projects, and obtain funding.

Montgomery County's designated Prevention Coordinator works in the Health Promotion and Prevention Section in the Department of Health and Human Services.

Finding #17: An array of committees, councils, and other groups in the County currently works on various aspects of ATOD prevention for school-age youth.

During the course of conducting research for this IBR project, OLO identified 11 groups that work on some aspect of ATOD prevention for school-age youth. Some of these groups were created more than a decade ago; others came into existence only recently. In alphabetical order, these groups are:

- Alcohol and Other Drug Abuse Advisory Council;
- Collaboration Council's Ad Hoc Youth Strategies Consolidated Grant Work Group;
- Drawing the Line on Underage Alcohol Use;
- Healthy Montgomery Coalition;
- Hospitality Resource Panel;
- Montgomery County Community Partnership;
- The Prevention Network;
- Safe and Drug Free Schools Advisory Council;
- School Health Council;
- Substance Abuse Policy Leadership Team (formerly the Coordinating Council on Substance Abuse); and
- Tobacco Use Prevention and Cessation Coalition-Cigarette Restitution Fund.

Several of these groups include only government agency representatives, but most also include representatives from outside the government. A number of the groups target a specific substance (i.e., tobacco use, alcohol use) while others deal with all types of substance use and abuse. Many of the same individuals participate in more than one of the listed groups.

While the County's Prevention Coordinator as well as each of these groups may be performing valuable work, the need for more effective coordination was one of the three recommendations voiced by participants in OLO's inter-agency worksessions on prevention. (see Findings #20 and #21 below)

PERFORMANCE DATA FOR THE COUNTY'S PREVENTION PROGRAMS

Finding #18: Most of the prevention programs in the County collect and report activity or workload data. In some cases, some intermediate program results are also collected.

Examples of the performance measures reported by prevention programs in the County according to dominant strategy used are:

Information dissemination: number of newsletters produced; flyers distributed; videos/books loaned; literature reviews sent out.

Prevention education: number and characteristics of participants; participants' ratings of facilitator/teacher; and pre- and post-testing of participants' knowledge about and attitudes towards substance use.

Alternative activities: number/type of activities; number of participants; changes in participants' report cards.

Problem identification and referral: number of referrals; age, gender, and grade of youth referred; number of youth "successfully" diverted to a prevention education/treatment program.

Community based process: number of meetings attended; number of events held.

Environmental strategies: number/types of activities; number of meetings attended.

Finding #19: In Montgomery County, as in communities across the country, no data exist to quantify a cause-and-effect link between ATOD prevention activities and ATOD use rates.

Few of the prevention programs currently operating in Montgomery County were designed and implemented in ways that enable measurement of longer-term program outcomes. Montgomery County is not alone in this. Most prevention programs are not implemented with either the necessary control group(s) or data collection mechanisms needed for valid/reliable evaluation.

The exception to this in Montgomery County is only just now beginning. Specifically, MCPS is in the process of collecting data over time that will make possible reliable assessments of how participation in the ALERT and TNT programs affect rates of substance use/abuse. As noted above, both of these programs are also rated as model effective programs by the federal Center for Substance Abuse Prevention.

RESULTS OF INTER-AGENCY WORKSESSIONS ON PREVENTION

Finding #20: The three inter-agency worksessions held as part of this IBR resulted in specific recommendations aimed at improving the coordination and evaluation of program effectiveness.

The design of this IBR project included three facilitated worksessions among key representatives from County-funded agencies currently engaged in ATOD prevention activities for school-age youth. OLO invited the Montgomery County Public Schools, Montgomery County Council of PTAs, County Government Departments of Health and Human Services, Police, and Recreation, Community Use of Public Facilities, Collaboration Council, and the Housing Opportunities Commission to send a mix of senior management and front-line practitioners to the worksessions. (See Appendix P for a list of meeting participants.)

OLO's purpose for convening the three worksessions was to:

- Solicit agency views on current alcohol, tobacco, and other drug prevention activities that target school-age youth (pre-K through 12th grade) in Montgomery County;

- Identify where County practitioners and managers agree and disagree on current and potential ATOD prevention strategies for this age group; and

- Help OLO/Council staff develop recommendations to the Council on setting priorities for funding ATOD prevention activities for school age youth in the FY 03 operating budget.

The group agreed on three formal recommendations:

a. Raise the level of ATOD prevention planning, coordination, and oversight to a single, senior policy level group. This collaborative group should, for example, include County Government Department heads, high-level MCPS and HOC staff, and a Council representative.

b. Pool existing agency resources to evaluate the effectiveness of County (and other established) ATOD prevention programs and activities. This comprehensive, coordinated evaluation should:

- Begin with an in-depth review of existing research and County data;
- Serve as a basis for program planning, priority setting, and resource allocation;
- Serve as a basis for the development of a system of data collection, management, and analysis;
- Produce a series of additional recommendations in areas such as staffing, staff development, community outreach, and so forth; and
- Inaugurate a permanent ongoing, joint program evaluation.

c. Maintain FY02 funding levels for all current ATOD prevention programs and activities until after Recommendations #1 and #2 are implemented. The structures and processes outlined in these recommendations will position the County to make far more informed cost-benefit analyses and program funding decisions.

Finding #21: For a number of reasons, the inter-agency group was not able to place specific County prevention programs in priority order:

One of OLO's expected outcomes of the inter-agency worksessions was a consensus list of the group's top priority prevention programs based upon the group's assessment of which programs were most effective. The group was not able to do this for at least three reasons:

- Many participants were unfamiliar with the full array of prevention programs;
- While some participants were familiar with the sizable body of national prevention research, its collective familiarity with it was uneven;
- Because data and outcome evaluation have not been a major, uniform priority for the County's prevention programs, the data are not available to judge the effectiveness of specific interventions.

X. Recommendations

Alcohol and drug use among young people is associated with impaired school performance, physical abuse, unwanted pregnancies, non-fatal accidents, and other injuries. In addition, the early involvement with any drug is a risk factor for later substance abuse and criminal activity.

Prevention is arguably the most cost-effective approach to the problem of substance abuse. Preventing the County's youth from using alcohol, tobacco, and other drugs in the first place holds many advantages over paying later for the direct and indirect costs of substance abuse, i.e. treatment, rehabilitation, possible incarceration, lost productivity, and related social pathologies.

As reviewed earlier, an increasing volume of research documents that prevention programs can work to delay, reduce, or prevent altogether alcohol, tobacco, and drug use/abuse. The research has found that some programs do not work, some are promising but not proven, and others have yet to be tested adequately.

This chapter outlines five specific recommendations based upon OLO's views that:

- The Council should exercise its oversight and funding authority to promote sustained public attention to the importance of alcohol, tobacco, and other drug prevention in the County; and

- The allocation of local resources to prevention activities aimed at school-age youth should increasingly be guided by the research that tells us "what works" to delay, reduce, or prevent altogether the use of alcohol, tobacco, and other drugs.

Recommendation #1
The Council should address alcohol, tobacco, and other drug (ATOD) prevention for school age youth as a priority inter-agency issue.

This IBR project identified more than 30 County programs that cite as one of their primary goals the prevention of ATOD use by school-age youth. The Council appropriates funds for these programs through the budgets of the Montgomery County Public Schools, four County Government Departments, the Housing Opportunities Commission, the Office of the Sheriff, and the M-NCPPC Park Police.

Across agencies, FY 02 funding for these programs totaled $6.74 million, of which approximately $2 million (30%) was outside funds. The agencies' FY 03 budget requests propose total funding of $6.58 million (a net decrease of $161K or 2%) for these programs in the coming fiscal year.

The range of agencies using different approaches to deliver ATOD prevention programming in the County is not a problem in itself. In fact, it is consistent with the research findings that:

- No single prevention program is the "best" and no one program will stop all drug use; and
- The chances of positive outcome - to delay, reduce, or prevent altogether substance abuse - are increased if prevention programs influence young people across multiple "domains" of their lives, e.g., at school, at after-school activities, at home, in the community.

However, because prevention activities should be examined collectively and because the issue involves multiple agencies with separate budget processes , the Council should take an inter-agency approach to making funding decisions related to ATOD prevention.

Recommendation #2
The Council should establish two-year and five-year goals for reducing ATOD use by the County's youth.

A Council focus on ATOD prevention as a priority inter-agency issue will, by itself, help to sustain both agency and public attention on the issue. To help maintain this focus, OLO recommends that the Council adopt specific two-year and five-year goals for changes in alcohol, tobacco, and other drug use by the County's youth.

At the national level, for example, the 2001 National Drug Control Strategy adopted the following goals for adolescent drug use:

Two-year goal: A 10 percent reduction in current use of illegal drugs by the 12-17 age group.

Five-year goal: A 25 percent reduction in current use of illegal drugs by the 12-17 age group.

A process for tracking the County's progress towards meeting such goals is already in place. Every two years, the Maryland Department of Education surveys 6th, 8th, 10th, and 12th graders throughout the State on their use of alcohol, tobacco, and other drugs. The results, published for each county in the State, are considered accurate + or - 2.5% based upon a 95% confidence interval.

Recommendation #3

ATOD prevention planning and coordination across agencies should be the responsibility of a single, senior policy level group.

ATOD prevention programs for school-age youth delivered in the County should be well coordinated across agencies. Effective planning and coordination among programs promotes the following positive outcomes:

- The delivery of consistent prevention messages across programs;
- The design and implementation of prevention activities based on current knowledge of related activities; and
- The efficient use of available prevention resources.

This IBR project included three facilitated worksessions among representatives from the County agencies currently engaged in ATOD prevention activities. **Worksession participants recommended that the level of ATOD prevention planning, coordination, and oversight be raised to a single, senior level policy group.** The group recommended that membership include County Government department heads, senior staff from Montgomery County Public Schools, the Housing Opportunities Commission and other agencies as appropriate, and a Council representative.

OLO recommends that additional study is needed before a decision is made on how best to achieve inter-agency coordination. In particular, additional study will provide a fuller understanding of the roles and current practices of the existing Prevention Coordinator position (housed within the Department of Health and Human Services) and the array of groups that currently deal with one or more aspects of ATOD prevention. Of particular importance is the need to discern why the current structures have not worked effectively to achieve the desired level of communication and coordination among staff involved with prevention across the agencies.

The Council could ask OLO or other staff to do this additional work as a logical follow-up to this IBR project, with the goal of coming back with a specific recommendation for both a structure and agenda for future inter-agency coordination on ATOD prevention for school-age youth. For example, a first year agenda would need to address issues such as how best to:

- Share program, participant, and budget data across agencies;
- Publicize program information with parents and other community members;
- Access and apply the latest research on effective prevention strategies; and
- Join together to seek outside funding for prevention activities.

If assigned this work, OLO would examine the feasibility of using one of the existing groups, perhaps with a revised charter and/or modified membership, to serve as the entity for ongoing planning and coordination. In addition, OLO would examine the pros, cons, and feasibility of combining or eliminating one or more of the existing groups.

Recommendation #4

The Council should set a long-term policy goal of appropriating funds only to prevention programs and strategies for which there is science-based evidence of effectiveness.

The Council should adopt a long-term policy goal of limiting spending on ATOD prevention programs and strategies to those that can demonstrate evidence of effectiveness -- meaning that a science-based research study found the approach had a measurable, positive effect (to delay, reduce or prevent altogether) on participants' use of alcohol, tobacco, and/or other drugs.

Realizing this long-term policy goal does not require spending the County's limited prevention resources to conduct such evaluation. Science-based evaluation is expensive, time consuming, and methodologically challenging. Instead of conducting our own local evaluations of program effectiveness, OLO recommends that the County take full advantage of the results of the federal government's investment into researching the effectiveness of prevention programs and strategies throughout the country.

As discussed earlier in this report, at least four federal agencies (Center for Substance Abuse Prevention, National Institute on Drug Abuse, Office of Juvenile Justice and Delinquency Prevention, and US Department of Education) actively disseminate information about "effective" alcohol, tobacco, and other drug abuse prevention programs and strategies. Increasingly, the federal government is identifying "model" prevention programs that have produced a consistent pattern of positive results in multiple locations across multiple target populations, with consideration for age, gender, race/ethnicity, and geographic context.

While the body of empirical research is impressive and substantial progress has been made to identify model programs, OLO recognizes that we have not yet reached the point where jurisdictions can simply go shopping for "off-the-shelf" proven prevention programs of all types. The National Registry for Effective Prevention Programs (maintained by the Center for Substance Abuse Prevention) currently lists numerous model programs for prevention education delivered inside and/or outside the classroom. An increasing number of model programs combine prevention education with other types of strategies, e.g., alternative activities, problem identification and referral, community based process, and environmental approaches.

Over time, it is a reasonable expectation that the federal government's lists of model programs with science-based evidence of effectiveness will grow both in terms of numbers and types of programs and strategies. This is why OLO believes that the Council's long-term policy goal can and should be to limit funding to programs and strategies that have proven track records of actually delaying, reducing or outright preventing alcohol, tobacco, and drug use.

Recommendation #5

In the short term, the Council should approach funding ATOD prevention activities by:

- **Balancing the County's investment among universal, selective, and indicated programs;**
- **Placing funding priority on programs and strategies with proven effectiveness; and**
- **Not spending County funds on activities for which outside funds are available.**

For the reasons outlined in Recommendation #4, an alternative approach to requiring all programs to demonstrate science-based evidence of effectiveness is needed in the short-term. OLO recommends that the Council's immediate approach to funding ATOD prevention activities be guided by three principles:

(1) **Balance the County's investment among universal, selective, and indicated programs, and among programs that deliver prevention messages across multiple domains.** Funding a balance of universal, selective, and indicated prevention programs promotes a range of prevention approaches, recognizing that the County includes different target populations with different needs. The reason to support program delivery across different domains is based upon the research finding that the chances of positive outcomes are increased if prevention programs influence young people across multiple domains of their lives, e.g., at school, at after-school activities, at home, in the community.

(2) **Within each category, place priority on funding programs that can cite science-based evidence of effectiveness.** The primary reason for this principle is self-evident, that is, where relevant programs with a proven track record are available, it makes sense to spend money on activities that we know will accomplish their intended goal. A principle of placing funding priority on "what works" makes even more sense when resources are constrained.

(3) **Do not spend County dollars on activities for which non-County funds are available.** This IBR project identified more than $2 million of ATOD prevention activities for school-age youth that are supported by non-County funds, primarily in the form of State and federal grants. The principle of not spending County funds for activities that are eligible for outside funding becomes especially important when difficult decisions must be made about spending limited local dollars.

Note on specific FY 03 budget actions. If, after review of this IBR report, Councilmembers want to apply these principles (either as written or as modified by the Council) to their FY 03 budget decision-making on ATOD prevention across the agencies, then staff will prepare a list of potential FY 03 budget actions for Council consideration.

ALCOHOL, TOBACCO, AND OTHER DRUG PREVENTION PROGRAMS FOR SCHOOL-AGE YOUTH

LIST OF APPENDICES

Note: Appendix A is printed as one document and Appendices B through P as a second document.

CONTENTS NEXT SECTION PREVENTION PRINCIPLES BACK TO OPENING

Risk and Protective Factors

Q: What are risk factors and protective factors?

Studies over the past two decades have tried to determine the origins and pathways of drug abuse-how the problem starts and howit progresses. Several factors have been identified that differentiate those who use drugs from those who do not. Factors associated with greater potential for drug use are called "risk" factors, and those associated with reduced potential for such use are called "protective" factors.

Our research has revealed that there are many risk factors for drug abuse, each representing a challenge to the psychological and social development of an individual and each having a differential impact depending on the phase of development. For this reason, those factors that affect early development in the family are probably the most crucial, such as:

- chaotic home environments, particularly in which parents abuse substances or suffer from mental illnesses;
- ineffective parenting, especially with children with difficult temperaments and conduct disorders; and
- lack of mutual attachments and nurturing.

Risk and protective factors encompass psychological, behavioral, family, and social characteristics.

Other risk factors relate to children interacting with other socialization agents outside of the family, specifically the school, peers, and the community. Some of these factors are:

- inappropriate shy and aggressive behavior in the classroom;
- failure in school performance;
- poor social coping skills;
- affiliations with deviant peers or peers around deviant behaviors; and
- perceptions of approval of drug-using behaviors in the school, peer, and community environments.

Certain protective factors also have been identified. These factors are not always

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the opposite of risk factors. Their impact also varies along the developmental process. The most salient protective factors include:

- strong bonds with the family;
- experience of parental monitoring with clear rules of conduct within the family unit and involvement of parents in the lives of their children;
- success in school performance;
- strong bonds with prosocial institutions such as the family, school, and religious organizations; and
- adoption of conventional norms about drug use.

Other factors-such as the availability of drugs, trafficking patterns, and beliefs that drug use is generally tolerated-also influence the number of young people who start to use drugs.

Q: How can prevention planners use risk and protective factors to develop programs?

The study of factors and processes that increase the risk of using drugs or protect against the use of drugs has identified the following primary targets for prevention intervention: family relationships, peer relationships, the school environment, and the community environment. Some of the factors in each domain are briefly described below. Each of these domains can be a setting for deterring the initiation of drug use through increasing social- and self-competency skills, adoption of prosocial attitudes and behaviors, and awareness of the harmful health, social, and psychological consequences of drug abuse.

Prevention efforts can enhance protective factors and move toward reversing or reducing risk factors.

Family Relationships. Prevention programs can enhance protective factors among young children by teaching parents skills for better family communication, discipline, firm and consistent rulemaking, and other parenting skills. Research also has shown that parents need to take a more active role in their children's lives, including talking with them about drugs, monitoring their activities, getting to know their friends, and understanding their problems and personal concerns.

Peer Relationships. Prevention programs focus on an individual's relationship to peers by developing social-competency skills, which involve improved communications, enhancement of positive peer relationships and social behaviors, and resistance skills to refuse drug offers.

The School Environment. Prevention programs also focus on enhancing academic performance and strengthening students' bonding to school, by giving them a sense of identity and achievement and reducing the likelihood of their dropping out of school. Most curriculums include the support for positive peer relationships (described above) and a normative education component designed

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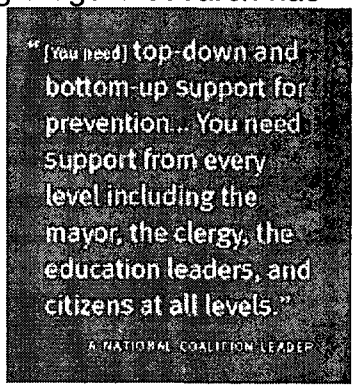
to correct the misperception that most students are using drugs. Research has found also that when children understand the negative effects of drugs (physical, psychological, and social) and when they perceive their friends' and families' social disapproval of drug use, they tend to avoid initiating drug use.

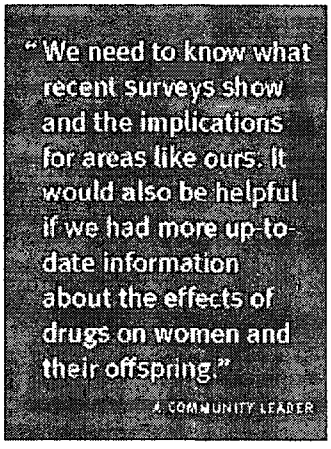


The Community Environment. Prevention programs work at the community level with civic, religious, law enforcement, and governmental organizations to enhance antidrug norms and prosocial behavior through changes in policy or regulation, mass media efforts, and communitywide awareness programs. Community-based programs might include new laws and enforcement, advertising restrictions, and drug-free school zones-all designed to provide a cleaner, safer, drug-free environment.

Educating children about the negative effects of drugs, especially the most immediate adverse effects in their lives, is an important element in any prevention program. In addition, helping children become more successful in school behavior and performance helps them form strong prosocial bonds with their peers, the school, and the community.

Q: What are the highest-risk periods for drug use among youth?

For most children, research has shown that the vulnerable periods are transitions, when they grow from one developmental stage to another. But exposure to risks can start even before a child is born; this is one reason that mothers are advised to abstain from drugs during pregnancy.



The first big transition for children is when they leave the security of the family and enter school. When they advance from elementary school to middle school or junior high, they often face social challenges, such as learning to get along with a wider group of peers. It is at this stage, early adolescence, that children are likely to encounter drug use for the first time.

Later on, when they enter high school, young people face social, psychological, and educational challenges as they prepare for the future, and these challenges can lead to use and abuse of alcohol, tobacco, and other drugs.

When young adults go on to college or get married or enter the workforce, they again face new risks from alcohol and other drug abuse in their new adult environments.

Because risks appear at every transition from infancy through young adulthood, prevention planners need to develop programs that provide support at each developmental stage.

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Q: When does drug use start, and how does it proceed?

Studies indicate that children most often begin to use drugs at about age 12 or 13, and many researchers have observed young teens moving from the illicit use of legal substances (such as tobacco, alcohol, and inhalants) to the use of illegal drugs (marijuana is usually the first). The sequence from tobacco and alcohol use to marijuana use, and then, as children get older, to other drugs, has been found in almost all long-term studies of drug use. The order of drug use in this progression is largely consistent with social attitudes and norms and the availability of drugs. But it cannot be said that smoking and drinking at young ages are the cause of later drug use.

Nor does this sequencing imply that the progression is inevitable. It does say that for someone who ever smoked or drank, the risk of moving on to marijuana is 65 times higher than that for a person who never smoked or drank. The risk of moving on to cocaine is 104 times higher for someone who smoked marijuana at least once in his or her lifetime than for a person who never did (these figures are from an analysis of 1991 - 1993 data from the National Household Survey on Drug Abuse).

Scientists have hypothesized several reasons for this observed progression, including a possible biological cause. The research also suggests social or behavioral causes, such as early involvement with antisocial, drug-using people. Indeed, all these possibilities could play a part.

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Risk Factors

Risk factors are characteristics that occur statistically more often for those who develop alcohol, tobacco, and other drug problems, either as adolescents or as adults. Recent research points to a considerable number of such factors, including individual, family, and social/cultural characteristics. The following chart from CSAP's publication *Breaking New Ground for Youth at Risk: Program Summaries. CSAP Technical Report 1* lists these factors:

1. **Community Environment**
   - Poverty
   - Living in an economically depressed area with:
     - high unemployment
     - inadequate housing
     - high prevalence of crime
     - high prevalence of illegal drug use
   - Minority status involving:
     - racial discrimination
     - culture devalued in American society
     - differing generational levels of assimilation
     - cultural and language barriers to getting adequate health care and other social services
     - low educational levels
     - low achievement expectations from society

2. **Family Environment**
   - Alcohol, tobacco, and other drug dependency of parent(s)
   - Parental abuse and neglect of children
   - Antisocial, sexually deviant, or mentally ill parents
   - High levels of family stress, including financial strain
   - Large, overcrowded family
   - Unemployed or underemployed parents
   - Parents with little education
   - Socially isolated parents
   - Single female parent without family/other support
   - Family instability
   - High level of marital and family conflict and/or family violence

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- *Constitutional Strengths*
  - Adequate early sensorimotor and language development
  - High intelligence
  - Physically robust
  - No emotional or temperamental impairments

- *Personality of the Child*
  - Affectionate/endearing
  - Easy temperament
  - Autonomous
  - Adaptable and flexible
  - Positive outlook
  - Healthy expectations
  - Self-efficacy
  - Self-discipline
  - Internal locus of control
  - Problem-solving skills
  - Socially adept
  - Tolerance of people and situations

If the high-risk environment is the family itself, for instance if children are growing up in an alcoholic or drug abusing family, studies suggest that they have a better chance of growing into healthy adulthood if they:

- Can learn to do one thing well that is valued by themselves, their friends, and their community;
- Are required to be helpful as they grow up;
- Are able to ask for help for themselves;
- Are able to elicit positive responses from others in their environment;
- Are able to distance themselves from their dysfunctional families so that the family is not their sole frame of reference;
- Are able to bond with some socially valued, positive entity, such as the family, school, community groups, or church;
- Are able to interact with a (perceived to be) caring adult who provides consistent caring responses.

Resiliency factors, along with risk factors, need to be more widely publicized for the use of parents, gatekeepers, and prevention planners. While many of the factors listed are the result of external forces, those factors that may be taught or instilled in children can provide some protection to youths at high risk for alcohol, tobacco, or other drug problems.

References

Youth at High Risk for Substance Abuse (1990) BKD06

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- Parental absenteeism due to separation, divorce, or death
- Lack of family rituals
- Inadequate parenting and low parent/child contact
- Frequent family moves

3. **Constitutional Vulnerability of the Child**
   - Child of an alcohol, tobacco, or other drug abuser
   - Less than 2 years between the child and its older/younger siblings
   - Birth defects, including possible neurological and neurochemical dysfunctions
   - Neuropsychological vulnerabilities
   - Physically disabled
   - Physical or mental health problems
   - Learning disability

4. **Early Behavior Problems**
   - Aggressiveness combined with shyness
   - Aggressiveness
   - Decreased social inhibition
   - Emotional problems
   - Inability to express feelings appropriately
   - Hypersensitivity
   - Inability to cope with stress
   - Problems with relationships
   - Cognitive problems
   - Low self-esteem
   - Difficult temperament
   - Personality characteristics of ego under-control, rapid tempo, inability to delay gratification, overreacting

5. **Adolescent Problems**
   - School failure and dropout
   - At risk of dropping out
   - Delinquency
   - Violent acts
   - Gateway drug use
   - Other drug use and abuse
   - Early unprotected sexual activity
   - Teenage pregnancy/teen parenthood
   - Unemployed or underemployed
   - At risk of being unemployed
   - Mental health problems
   - Suicidal

6. **Negative Adolescent Behavior and Experiences**
   - Lack of bonding to society (family, school, and community)
   - Rebelliousness and nonconformity

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Resilience/Protective Factors

Many youths, although living in high-risk environments, seem to possess personal resilience that helps them avoid alcohol, tobacco, and other drug problems. One current challenge to the prevention field is to identify these protective factors and determine how they can be instilled in all youth in high-risk environments.

The following is a checklist of youth protective factors:

1. *Community Environment*
    - Middle or upper class
    - Low unemployment
    - Adequate housing
    - Pleasant neighborhood
    - Low prevalence of neighborhood crime
    - Good school
    - School that promotes learning, participation, and responsibility
    - High-quality health care
    - Easy access to adequate social services
    - Flexible social service providers who put clients' needs first

    - *Family Environment*
        - Adequate family income
        - Structured and nurturing family
        - Parents promote learning
        - Fewer than four children in family
        - Two or more years between the birth of each child
        - Few chronic stressful life events
        - Multi-generational kinship network
        - Non-kin support network, e.g., supportive role models, dependable substitute child care
        - Warm, close personal relationship with parent(s) and/or other adult(s)
        - Little marital conflict
        - Family stability and cohesiveness
        - Plenty of attention during first year of life
        - Sibling as caretaker/confidante
        - Clear behavior guidelines

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- Resistance to authority
- Strong need for independence
- Cultural alienation
- Fragile ego
- Feelings of failure
- Present versus future orientation
- Hopelessness
- Lack of self-confidence
- Low self-esteem
- Inability to form positive close relationships
- Vulnerability to negative peer pressure

It is important to recognize that risk factors are only indicators for the potential of problem occurrence. While they can be helpful in identifying children who are vulnerable to developing alcohol, tobacco, or other drug problems, they are not necessarily predicative for an individual child. Children growing up under adverse conditions often mature into healthy, well-functioning adults. In addition, the use of risk factors to label children poses its own risk. Consequently, there is increasing attention on those factors that seem to protect children from developing alcohol, tobacco, or other drug problems.

There are no simple solutions for helping youth at high risk for developing alcohol, tobacco, or other drug problems. Reducing risk factors and fostering resiliency are part of a comprehensive approach to prevention, and are consistent with a public health approach to reducing problems.

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Types of Prevention Strategies

Western Regional Center for the Application of Prevention Technologies (CAPT)

(Excerpt from *"Drug Abuse Prevention: What Works"*, National Institute of Drug Abuse, 1997, p. 10-15)

Universal | Selective | Indicated

In a 1994 report on prevention research, the Institute of Medicine (IOM 1994) proposed a new framework for classifying prevention based on Gordon's (1987) operational classification of disease prevention. The **IOM model** divides the continuum of care into **three parts**: prevention, treatment, and maintenance. The **prevention category** is divided into **three classifications**--universal, selective and indicated prevention interventions, which replace the confusing concepts of primary, secondary, and tertiary prevention. Although the IOM system distinguishes between prevention and treatment, ***intervention*** in this context is used in its generic sense and should *not* be construed to imply an actual treatment protocol.

Universal

Universal prevention strategies address the entire population (national, local community, school, neighborhood), with messages and programs aimed at preventing or delaying the abuse of alcohol, tobacco, and other drugs. For example, it would include the general population and subgroups such as pregnant women, children, adolescents, and the elderly. The mission of universal prevention is to deter the onset of substance abuse by providing all individuals the information and skills necessary to prevent the problem. All members of the population share the same general risk for substance abuse, although the risk may vary greatly among individuals. Universal prevention programs are delivered to large groups without any prior screening for substance abuse risk. The entire population is assessed as at-risk for substance abuse and capable of benefitting from prevention programs.

Selective

Selective prevention strategies target subsets of the total population that are deemed to be at risk for substance abuse by virtue of their membership in a particular population segment--for example, children of adult alcoholics, dropouts, or students who are failing academically. Risk groups may be identified on the basis of biological, psychological, social, or environmental risk factors known to be associated with substance abuse (IOM 1994), and targeted subgroups may be defined by age, gender, family history, place of residence such as high drug-use or low-income neighborhoods, and victimization by physical and/or sexual abuse. Selective prevention targets the entire subgroup regardless of the degree of risk of any individual within the group. One individual in the subgroup may not be at personal risk for substance abuse, while another person in the same subgroup may be abusing substances. The selective prevention program is presented to the entire subgroup because the subgroup as a whole is at higher risk for substance abuse than the general population. An individual's personal risk is not specifically assessed or identified and is based solely on a presumption given his or her membership in the at-risk subgroup.

Indicated

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Indicated prevention strategies are designed to prevent the onset of substance abuse in individuals who do not meet DSM-IV criteria for addiction, but who are showing early danger signs, such as falling grades and consumption of alcohol and other gateway drugs. The mission of indicated prevention is to identify individuals who are exhibiting early signs of substance abuse and other problem behaviors associated with substance abuse and to target them with special programs. The individuals are exhibiting substance abuse-like behavior, but at a subclinical level (IOM 1994). Indicated prevention approaches are used for individuals who may or may not be abusing substances, but exhibit risk factors that increase their chances of developing a drug abuse problem. Indicated prevention programs address risk factors associated with the individual, such as conduct disorders, and alienation from parents, school, and positive peer groups. Less emphasis is placed on assessing or addressing environmental influences, such as community values. The aim of indicated prevention programs is not only the reduction in first-time substance abuse, but also reduction in the length of time the signs continue, delay of onset of substance abuse, and/or reduction in the severity of substance abuse. Individuals can be referred to indicated prevention programs by parents, teachers, school counselors, school nurses, youth workers, friends, or the courts. Young people may volunteer to participate in indicated prevention programs.

[*NOTE:* **In the majority of cases, indicated strategies would be the most appropriate strategies for youth already involved with the juvenile justice system.**]

Resources

 **For more information** on the three types of prevention strategies, you can order "Drug Abuse Prevention:
What Works" by National Institute on Drug Abuse (1997).

To obtain a copy, contact National Technical Information Services at (800) 553-6847 (Publication number PB# 97-209605). This book is part of a 5 book packet which costs $83 plus $5 handling.

For comments or questions about web-site, contact Kristen Reed Gabrielsen, Associate Director, 1-888-734-7476.

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- the environment—the setting in which the substance using behavior occurs, including the community mores, or norms, that shape the behavior.

Prevention strategies can focus on any of these targets. Attempts to change the agent are considered supply reduction strategies; attempts to alter the individual's desire for the substance are demand reduction strategies. Environmental strategies focus on the surroundings of the substance abuser: the community, school, or workplace. Environmental prevention strategies can be used for supply and demand reduction.

Within the public health classification of prevention, antidrug efforts have been organized along a continuum of primary, secondary, and tertiary prevention (Commission on Chronic Illness 1957; CSAP 1991). The goal of primary prevention is to protect individuals who have not begun to use substances, thereby decreasing the incidence of new users. The goal of secondary prevention (also called *early intervention) is* to intervene with persons in the early stages of substance abuse or exhibiting problem behaviors associated with substance abuse to reduce and/or eliminate substance use. The goal of tertiary prevention is to end substance dependency and addiction and/or ameliorate the negative effects of substance abuse through treatment and rehabilitation. In this model, tertiary prevention is most often referred to as *treatment,* but also includes rehabilitation and relapse prevention. The public health classification of prevention has been criticized by practitioners as confusing, particularly in its failure to distinguish secondary prevention (early intervention) from primary prevention or tertiary prevention (treatment).

The Institute of Medicine Classification System

In a 1994 report on prevention research, the Institute of Medicine (IOM 1994) proposed a new framework for classifying prevention based on Gordon's (1987) operational classification of disease prevention. The IOM model divides the continuum of care into three parts: prevention, treatment, and maintenance. The prevention category is divided into three classifications—universal, selective, and indicated prevention interventions, which replace the confusing concepts of primary, secondary, and tertiary prevention. NIDA has adopted this classification system. Although the IOM system distinguishes between prevention and treatment, *intervention* in this context is used in its generic sense and should *not* be construed to imply an actual treatment protocol. The last section of this chapter discusses the interface of prevention, treatment, and maintenance.

Within the IOM classification system, prevention programs are organized along a targeted audience continuum—that is, the degree to which any person is identified as an individual at risk for substance abuse. The at-risk determination is based on a combination of risk and protective factors associated with substance abuse. A *risk factor is* an association between some characteristic or attribute of an individual, group, or environment and an increased probability of certain disorders or disease-related phenomena at some point in time (Berman and Jobes 1991). *Protective factors* inoculate, or protect persons and can strengthen their determination to reject or avoid substance abuse. Protective factors can inhibit self-destructive behaviors and situations that advance substance abuse. These are discussed in the next chapter. The universal, selective, and indicated prevention interventions represent the population groups to whom the interventions are directed and for whom they are thought to be optimal, given an assessment of risk and protective factors.

Universal prevention strategies address the entire population (national, local community, school, neighborhood), with messages and programs aimed at preventing or delaying the abuse of alcohol, tobacco, and other drugs. Selective prevention strategies target subsets of the total population that are deemed to be at risk for substance abuse by virtue of their membership in a particular population segment—for example, children of adult alcoholics, dropouts, or students who are failing academically. Indicated prevention strategies are designed to prevent the onset of substance abuse in individuals who do not meet DSM-III-R or DSM-IV criteria for

addiction, but who are showing early danger signs, such as falling grades and consumption of alcohol and other gateway drugs.

These three types of prevention interventions do not correspond well with the public health model of primary, secondary and tertiary prevention. The overall aim of all of these strategies is to reduce the number of new cases of substance abuse, as defined by the DSM-III-R or DSM-IV. These interventions are designed to reduce the length of time that the early signs of substance abuse continue and to halt the severity and intensity of the progression of substance abuse. These interventions also are intended to reduce the severity and intensity of the problem so that the individuals at risk for substance abuse do not go on to require a clinical diagnosis of the disorder.

Universal Preventive Intervention Strategies

A universal preventive intervention is one that is desirable for all members of a given population. For example, it would include the general population and subgroups such as pregnant women, children, adolescents, and the elderly. The mission of universal prevention is to deter the onset of substance abuse by providing all individuals the information and skills necessary to prevent the problem. All members of the population share the same general risk for substance abuse, although the risk may vary greatly among individuals. Universal prevention programs are delivered to large groups without any prior screening for substance abuse risk. The entire population is assessed as at-risk for substance abuse and capable of benefiting from prevention programs (IOM 1994).

The risk and protective factors addressed in universal prevention programs may reflect some individual or subgroup characteristics, but primarily reflect environmental influences such as community values, school support, economic and employment stability, and so on. For example, some individuals may be physically and emotionally happy; they may be academically successful and have a wide circle of friends who also are academically successful; they may be involved in a variety of positive school activities; they may have families who are supportive and have solid positive values; and they may have high self-esteem and a sense of purpose in life. All these factors would serve to protect these individuals from drug abuse. Other individuals may be failing in school or work and come from dysfunctional families. All of these people may live in communities where there is a high rate of crime, drug dealing, and community dysfunction. Regardless of their individual risk for substance abuse, all of these people could benefit from universal prevention strategies.

General examples of universal preventive interventions include the use of seat belts, immunizations, prenatal care, and smoking prevention (IOM 1994). Examples of universal preventive interventions for drug abuse include substance abuse education for all children within a school district, media and public awareness campaigns within inner-city neighborhoods, and school policy changes regarding drug-free zones.

Universal prevention programs vary in type, structure, and design and can include school family-, and community-based programs. An example of a school-based universal program is the life skills training program described by Botvin and colleagues (Botvin et al. 1990a). Universal family-based programs include dissemination efforts to families within the general population, such as the *Preparing for the Drug-Free Years (PDFY)* program of Hawkins and colleagues (Hawkins et al. 1987). This program was implemented through school and community agencies in Oregon. An example of a community-based universal prevention approach that involves multiple program elements that are delivered within a broad community context is the *Midwestern Prevention Project (Project STAR)* developed by Pentz and colleagues (Pentz et al. 1990). This program is described in more detail later in this handbook and in the stand-alone document *Drug Abuse Prevention for the General Population.*

Key Features of Universal Prevention Programs

Regardless of the specific focus of universal prevention programs, they all share common characteristics. These include the following:

- The programs are designed to reach the entire population, without regard to individual risk factors, and they generally are designed to reach a very large audience;
- They are designed to delay or prevent substance abuse;
- Participants are not recruited to participate in the programs;
- The degree of individual substance abuse risk of the program participants is not assessed—the program is communicated to everyone in the population regardless of whether they are at risk for substance abuse;
- The programs usually have lower staff-to-audience member ratios than selective or indicated programs and may require less time and effort from the audience;
- Staff members can be professionals from other fields, such as teachers or school counselors, who have been trained to deliver the program; and
- Costs are spread over a large group and tend to be lower on a per-person basis than selective and indicated programs.

Selective Preventive Intervention Strategies

Selective prevention interventions target specific subgroups that are believed to be at greater risk than others. Risk groups may be identified on the basis of biological, psychological, social, or environmental risk factors known to be associated with substance abuse (IOM 1994), and targeted subgroups may be defined by age, gender, family history, place of residence such as high drug-use or low-income neighborhoods, and victimization by physical and/or sexual abuse. Selective prevention targets the entire subgroup regardless of the degree of risk of any individual within the group. One individual in the subgroup may not be at personal risk for substance abuse, while another person in the same subgroup may be abusing substances. The selective prevention program is presented to the entire subgroup because the subgroup as a whole is at higher risk for substance abuse than the general population. An individual's personal risk is not specifically assessed or identified and is based solely on a presumption given his or her membership in the at risk subgroup.

The risk factors assessed and addressed in selective prevention programs reflect both individual and subgroup characteristics (for example, high sensation seekers, delinquent peer group associations, familial substance abuse), as well as environmental influences like high rates of crime, unemployment, and community disorganization. For example, one subgroup may have physical or mental health problems, experience academic difficulties and school failure, yet live in neighborhoods with low crime rates and high employment (protective factors). They share risk factors with the subgroup as a whole and are considered part of the subgroup for purposes of selective preventive interventions.

General examples of selective preventive interventions include home visitation and infant daycare for low birth-weight children and annual mammograms for women with a family history of breast cancer (IOM 1994). Examples of selective preventive interventions for substance abuse include special clubs and groups for children of alcoholics, rites of passage programs for at-risk males, and skills training programs that target young

children of substance-abusing parents. The children may be drug-free but are at risk of subsequently developing drug abuse.

Generally, selective prevention programs are operated in schools or community agencies. Some selective prevention programs include education and skills training programs. Other selective prevention approaches include mentoring and tutoring. The *Strengthening Families Program* developed by Kumpfer and colleagues (Kumpfer et al. 1989) is an example of a family focused selective prevention program. This program is described later in this handbook and is presented in a separate stand-alone document *Drug Abuse Prevention for At-Risk Groups.*

Key Features of Selective Prevention Programs

Key features shared by selective prevention programs include the following:

- Programs target subgroups of the general population that are determined to be at risk for substance abuse;
- They are designed to delay or prevent substance abuse;
- Recipients of selective prevention are known to have specific risks for substance abuse and are recruited to participate in the prevention effort because of that group's risk profile;
- The degree of individual vulnerability or personal risk of members of the targeted subgroup generally is not assessed, but vulnerability is presumed on the basis of their membership in the at-risk group;
- Knowledge of specific risk factors within the target group allows program designers to address specific risk reduction objectives;
- Selective prevention programs generally run for a longer period of time and require more time and effort from participants than universal programs;
- Selective programs require skilled staff because they target multiproblem youth, families, and communities that are at risk for substance abuse;
- The programs may be more expensive per person than universal programs because they require more time and effort; and
- The program activities generally are more involved in the daily lives of the participants and attempt to change the participants in specific ways, for example, by increasing participants' communication skills.

Indicated Preventive Intervention Strategies

The mission of indicated prevention is to identify individuals who are exhibiting early signs of substance abuse and other problem behaviors associated with substance abuse and to target them with special programs. The individuals identified at this stage, though showing signs of early substance use, have not reached the point where a clinical diagnosis of substance abuse, as defined by DSM-III-R or DSM-IV criteria, can be made. They are exhibiting substance abuse-like behavior, but at a subclinical level (IOM 1994). Indicated prevention approaches are used for individuals who may or may not be abusing substances, but exhibit risk factors—such as school failure, interpersonal social problems, delinquency, and other antisocial behaviors, and psychological

problems such as depression and suicidal behavior—that increase their chances of developing a drug abuse problem. Indicated prevention programs address risk factors associated with the individual, such as low self-esteem, conduct disorders, and alienation from parents, school, and positive peer groups. Less emphasis is placed on assessing or addressing environmental influences, such as community values. The aim of indicated prevention programs is not only the reduction in first-time substance abuse, but also reduction in the length of time the signs continue, delay of onset of substance abuse, and/or reduction in the severity of substance abuse. Individuals can be referred to indicated prevention programs by parents, teachers, school counselors, school nurses, youth workers, friends, or the courts. Young people may volunteer to participate in indicated prevention programs.

General examples of indicated prevention in the health field include training programs for children experiencing early behavioral problems, medical control of hypertension, and regular examinations of persons with a history of basal cell skin cancer (IOM 1994). In the field of substance abuse, an indicated preventive intervention would be a substance abuse program for high school students who are experiencing a number of problem behaviors, including truancy, falling academic grades, juvenile depression, suicidal ideation, and early signs of substance abuse. Other examples of indicated substance abuse prevention programs include student assistance programs, where teachers and counselors refer students showing academic, behavioral, and emotional problems to counseling groups and family-focused programs for the prevention of substance abuse.

An example of a family-focused indicated prevention program is the *Structural Family Therapy* program developed by Szapocznik and colleagues (Szapocznik et al. 1989a). An example of a school-based indicated prevention program is the *Reconnecting Youth Program* developed by Eggert and colleagues (Eggert et al. 1990). This school-based program is designed for youth already engaged in substance abuse and/or other negative behaviors, such as truancy, emotional distress, and acting-out. This program is described later in this handbook and in the stand-alone document *Drug Abuse Prevention for At-Risk Individuals.*

Key Features of Indicated Prevention Programs

The key features shared by indicated prevention programs include the following:

- Programs target individuals who are experiencing early signs of substance abuse and other related problem behaviors;
- Programs are designed to stem the progression of substance abuse and related disorders:
- Programs can target multiple behaviors simultaneously;
- Individuals are specifically recruited for the prevention intervention;
- The individual's risk factors and problem behaviors are specifically addressed;
- Programs require a precise assessment of an individual's personal risk and level of related problem behaviors, rather than relying on the person's membership in an at-risk subgroup;
- Programs are frequently extensive and highly intensive; they typically operate for longer periods of time (months), at greater frequency (one hour per day, five days a week), and require greater effort on the part of the participants, than do selective or universal programs;
- Programs attempt to change the participants' behaviors;

- Programs require highly skilled staff that have clinical training and counseling or other clinical intervention skills; and

- Programs may be more expensive per person to operate than either universal or selective programs because they require more intensive work with individuals and small groups and more highly skilled staff.

Prevention Versus Treatment

Prevention and treatment are both designed to reduce the demand for drugs. Prevention attempts to reduce demand by decreasing risk factors and increasing protective factors associated with substance abuse, and treatment addresses clinically diagnosed substance abuse and reduces the negative effects associated with drug dependency and addiction. The essential difference between these strategies is that prevention addresses a problem *before* it occurs, and treatment addresses the problem *after it* occurs and is clinically diagnosed. IOM (1994) divides treatment into two components: case identification and standard treatment for known disorders.

In the IOM nomenclature, neither treatment nor maintenance plays a part in prevention. In fact, the sole focus of prevention efforts is on decreasing the degree of vulnerability to substance abuse of the target audience. Within this system, vulnerability is defined by the relative balance between the risk and protective factors of the target audience.

The IOM classification system views prevention and treatment on a spectrum of intervention that concludes with maintenance. According to IOM (1994), maintenance interventions are supportive, educational, and/or pharmacological in nature and are provided on a long-term basis to persons who have met the DSM-III-R or DSM-IV diagnostic criteria for substance abuse. In the drug abuse field, maintenance includes relapse prevention efforts to deter recurrence and aftercare and rehabilitation programs to reintegrate into society.

This chapter has identified prevention as one type of antidrug abuse strategy: namely, demand reduction. The discussion presented the rationale for establishing three categories of research-based prevention approaches—universal, selective, and indicated. The key features of each of these prevention approaches were listed, and the relationship of risk and protective factors to the use of universal, selective, and indicated prevention program strategies was described. The chapter concluded with a discussion of the distinction between substance abuse prevention and treatment.

The next chapter will discuss risk and protective factors and who is at risk for substance abuse and related problems. The chapter will briefly examine the focus of prevention programs on resiliency and then will describe some effective prevention program strategies. Finally, some guidelines for effective prevention programming will be presented.

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Drug Use Consequences

Drug- and Alcohol-Related Deaths: [6]

Year	Number
2000	18
1999	20
1998	14
1997	21
1996	18

Alcohol- and Drug-Related (ADR) Motor Vehicle Fatalities: [7]

ADR motor vehicle fatalities as a percentage of total motor vehicle fatalities

Year	Total Fatalities	ADR Fatalities	Percentage ADR-Related
1999	49	12	24%
1998	46	13	28
1997	54	16	30
1996	49	7	14
1995	72	20	28

Number of Juvenile Arrests for Driving Under the Influence: [8]

Year	Number
1999	58
1998	63
1997	44
1996	39
1995	23

Total Crashes Involving Drivers aged 16-20 Driving Under the Influence: [9]

Year	Number
1999	127
1998	100
1997	119
1996	94
1995	87

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Source: Center for Substance Abuse Research, University of Maryland

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Laboratory.

[5] SOURCE: Adapted by the Center for Substance Abuse Research from data supplied by the Maryland State Department of Education.

[6] SOURCE: Adapted by the Center for Substance Abuse Research from data supplied by the Maryland State Medical Examiner's Office. These numbers only reflect autopsies completed by the Medical Examiner's Office.
NOTE: A drug or alcohol death is a death due to an overdose of narcotics, cocaine, alcohol, or a combination of these drugs.

[7] SOURCE: Maryland Department of Transportation, State Highway Administration

[8] SOURCE: Adapted by the Center for Substance Abuse Research from data supplied by the Maryland State Police, Central Records Division, Uniform Crime Reporting Section.
NOTE: "Juvenile" refers to age 17 and under.

[9] SOURCE: Adapted by the Center for Substance Abuse Research from data supplied by the Maryland State Police, Central Records Division, Uniform Crime Reporting Section.

[10] SOURCE: Adapted by the Center for Substance Abuse Research from data from the Substance Abuse Management Information System.

[11] SOURCE: Adapted by the Center for Substance Abuse Research from data from the Substance Abuse Management Information System.

[12] SOURCE: Adapted by the Center for Substance Abuse Research from data from the Substance Abuse Management Information System.

[13] NOTE: The dropout rate is reported as the percentage of students in grades 9-12 who withdrew from school before graduation or before completing an approved educational program during the July-June academic year.
SOURCE: Maryland State Department of Education, Maryland School Performance Report, 1994 and 1996 State and Local School Systems.

[14] NOTES: The number of violent and property crimes is based on counts of actual offenses established by police investigation. In 1996, 3 percent of complaints received by the police were determined to be unsubstantiated. The 'crime rate' refers to the number of crimes per 100,000 population. Violent crimes, as classified by the Maryland State Police, are murder/nonnegligent manslaughter, forcible rape, robbery, and aggravated assault, while property crimes are breaking or entering, larceny/theft, and motor vehicle theft.
SOURCE: Maryland State Police, Uniform Crime Reporting Section

[15] NOTES: A juvenile is counted as "arrested" when the circumstances are such that, if the juvenile were an adult, an arrest would have absolutely been made, or when police or other official action is taken beyond a preliminary interview or simple warning or admonishment. Arrest figures simply indicate the number of these 'arrests' made - they do not represent the number of people arrested or summonsed since one person may be arrested several times during the reporting period. The juvenile arrest rate was calculated by dividing the number of arrests of persons aged 17 and under by the number of 10-17 year olds in the population. In 1996, 1100 juveniles under age 10 were arrested.
SOURCE: Arrest data provided by Maryland State Police, Uniform Crime Reporting Section. Population data provided by the Division of Health Statistics, Department of Health and Mental Hygiene.

[16] NOTE: OPUS provides insight into emerging drug trends among juvenile. These drug use patterns may not be typical of the general youth population. However, prior resaerch indicates offender urinalysis results may predict future drug epidemics in the general population.

[17] NOTE: Reports the percentage of positive drug tests among those arrestees tested by urinalysis

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Contact our toll-free Maryland hotline, 1-877-234-DEWS or email dews@cesar.umd.edu to help identify new drugs on the street, possible health effects, and changes in use or users.

Last Updated on Tuesday, October 23, 2001

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CHAPTER II

METHODOLOGY

POPULATION

The 2001 Maryland Adolescent Survey was administered to samples of sixth, eighth, tenth, and twelfth graders in public middle and high schools in every school system in Maryland. Certain special schools, such as home and hospital schools, and evening schools were not included in the study. The schools excluded from this sampling frame are listed in Appendix A.

SAMPLING PLAN

To ensure a statistically generalizable result for each grade at the school system level, the study used a multistage stratified cluster sample. First, the required sample size for each local school system was determined based on the system enrollments in each grade and the desired level of measurement precision (95% confidence interval of 5%). This sample size was adjusted based on the desirability of selecting two classes from most schools, the assumed class size, and the assumed absentee and refusal rate. Finally, the number of schools required in the sample was dictated by the number of classes to be studied. The sample was designed to ensure an equal probability of selection for every student at each grade level in each local school system (LSS).

Selection of Schools

In large school systems[1], the schools were stratified using participation in the school lunch program and ethnic composition. The number of students to be sampled for each grade level were allocated to each stratum proportional to the number of students enrolled at schools in the stratum. Schools were selected with probabilities proportional to the enrollment at the sixth, eighth, and twelfth grades respectively, and proportional to the total enrollment at the tenth and twelfth grade combined. This last feature is a departure from the procedure used in the previous study, but was implemented given the presence of a number of schools in which there is a wide disparity in the number of students between the tenth and twelfth grades. By using the combined enrollment the sample avoids great disparity in weights (and hence increased variance) in any given grade. In schools where the tenth or twelfth grade is selected, the other grade was also selected. After a school was selected, two classes per grade were chosen. Very small schools were combined with larger schools and classes were selected from the combination. This became necessary when a school was expected to have fewer than two classes available for selection.

In medium size school systems, stratification was unnecessary because the majority of schools were included in the sample. In these school systems, the opportunity for each school's

[1] Large school systems were: Anne Arundel, Baltimore City, Baltimore County, Montgomery and Prince George's. Medium school systems were: Allegany, Carroll, Cecil, Charles, Frederick, Harford, Howard, Washington, and Wicomico. Small school systems were: Calvert, Caroline, Dorchester, Garrett, Kent, Queen Anne's, St. Mary's, Somerset, Talbot, and Worcester.

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selection was again proportional to its enrollment for each grade, exactly as was done for each stratum in the large systems. Here we allowed a school to be selected more than once if it is very large. This was necessary to guarantee an equal probability of selection at every grade level. In small school systems, all schools were sampled, but the number of classes was adjusted to assign each student in the county the same probability of selection.

In the 1998 MAS, Prince George's County was oversampled due to a high expected non-response rate. This was not done for the 2001 MAS because Prince George's County did not require parental consent for participation as it had done in 1998.

Selection of Classes

Classes were designated as eligible for selection according to the criterion that all students in the school within the survey grades were enrolled in them and that no student could be enrolled in more than one class. In grades six and eight, these were most often classes such as English or Language Arts. In grades ten and twelve, some were English classes and the remaining classes sampled were drawn from within specified time blocks. Each school provided a list of classes within the specific time block (e.g., Period 2 or between 1:15 p.m. and 2:00 p.m.) during which all survey-eligible students were enrolled in one or another class. The classes sampled were drawn from the lists of classes within the designated time block.

Within each selected class, every survey-eligible sixth, eighth, tenth, and twelfth grade student was asked to complete a questionnaire. Other enrollees were excused from participation. Table 2.1 indicates that between 13% and 16% of enrolled students in each of the grades were in the initial sample statewide and between 11% and 12% were in the final sample.

Table 2.1: ELIGIBLE POPULATION, INITIAL SAMPLE, AND FINAL SAMPLE

Grade	Total Enrolled Population in Maryland[1]	Initial Sample		Final Sample	
	N	N	%	N	%
6th	67,323	8,911	13%	7,676	11%
8th	64,647	8,864	14%	7,336	11%
10th	62,410	8,439	14%	6,614	11%
12th	50,962	8,303	16%	6,078	12%

[1] SOURCE: Maryland Public School Enrollment by Race/Ethnicity and Gender and Number of Schools, September 30, 2000: MSDE

Weighting of Responses

In accordance with the sampling procedures, each school system was selected as a stratum. Within each school system, schools were selected for participation; within each school, classes were designated; within each class, all eligible students were requested to participate. This approach led to equal probabilities of selection for each student at each grade level. However, in order to control for differential participation rates, responses were weighted to account for the race/ethnicity and gender totals in each school system. Thus the weights were adjusted so as to add up to each total.

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For students with missing race/ethnicity or gender, the missing category was imputed using a hotdeck approach. Using the hotdeck approach, a student from the same school and grade was randomly selected and the ethnicity or gender category of the randomly selected student was assigned to the student with a missing value, for weighting purposes only.

Initial weights were obtained by calculating the probability of selection of each respondent in the survey. Initial weights were calculated by multiplying the probability of selection of the school (which will be 1.0 in the small schools systems) times the probability of selection of the student given that the school was selected. This last probability takes into account the fact that in some LSSs the addition of classes beyond two may be assigned using a random factor. The multiplicative inverse of this initial probability constitutes an initial weight. Initial weights were then adjusted to account for missing and refusing students.

The next step was the trimming of the weights. This is a procedure used to reduce extreme weights. The sampling procedure is designed to obtain equal weights for all students in the same LSS. However, low response rates in a school or a discrepancy between frame information and the number of students enrolled can lead to weights that are too large and this will increase variances. Weights were trimmed while preserving the sum of the weights in each LSS, using a procedure known as the *NAEP* method due to its use in the National Assessment of Educational Progress. Finally, the weights were adjusted so they added up to the LSS's calculation of the number of students of each ethnicity for each grade.

Survey Return Rates

A total of 34,517 questionnaires were sent to schools for completion by the designated sample of their students. Of these, 27,704 were returned and analyzed. Table 2.2 shows the number of survey forms sent out and returned for each participating school system. At the LSS level, return rates varied from a high of 88% to a low of 67%.

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Table 2.2: RESPONSE RATES FOR 2001 MAS BY SCHOOL SYSTEM[1]

School System	Grade								Total	
	6		8		10		12			
	Initial	Final	Initial	Final	Initial	Final	Initial	Final	Initial	Final
Allegany	386	94%	368	89%	348	66%	346	73%	1448	81%
Anne Arundel	457	75%	475	68%	452	67%	456	67%	1840	69%
Baltimore City	503	71%	493	65%	466	65%	477	69%	1939	67%
Baltimore	500	84%	484	91%	477	85%	487	78%	1948	84%
Calvert	380	79%	366	88%	340	86%	364	62%	1450	79%
Caroline	263	91%	279	88%	239	85%	184	70%	965	85%
Carroll	430	91%	461	94%	405	75%	400	80%	1696	85%
Cecil	349	87%	377	90%	360	88%	350	68%	1436	84%
Charles	405	87%	407	89%	402	78%	410	71%	1624	81%
Dorchester	271	90%	240	82%	243	61%	153	59%	907	75%
Frederick	405	83%	420	82%	477	84%	461	80%	1763	82%
Garrett	259	94%	248	70%	249	90%	247	84%	1003	85%
Harford	435	94%	471	82%	387	78%	418	78%	1711	83%
Howard	428	81%	491	88%	502	81%	475	75%	1896	81%
Kent	202	87%	184	90%	105	91%	132	76%	623	86%
Montgomery	428	91%	442	91%	438	82%	416	69%	1724	84%
Prince George's	476	92%	495	87%	474	69%	466	63%	1911	78%
Queen Anne's	421	92%	312	63%	267	84%	249	80%	1249	81%
St. Mary's	368	83%	297	76%	315	86%	315	77%	1295	81%
Somerset	209	89%	202	73%	193	88%	145	68%	749	80%
Talbot	258	87%	242	73%	245	60%	197	74%	942	74%
Washington	407	96%	406	90%	402	82%	439	84%	1654	88%
Wicomico	360	79%	397	88%	371	81%	362	85%	1490	83%
Worcester	311	80%	307	73%	282	86%	354	64%	1254	75%
Total	8911	86%	8864	83%	8439	78%	8303	73%	34517	80%

[1] Unusable responses not included.

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SAMPLE CHARACTERISTICS

As indicated in Table 2.3 below, the proportions of males and females that participated in the study from each of the four grades surveyed reflect those enrolled in these grades in the state as a whole. The proportions of respondents from each of the categories of race/ethnicity on which data were collected (Table 2.4) also reflect the proportion of the students enrolled in each of the grades studied. Table 2.4, however, suggests a small degree of over sampling of White and American Indian students and a corresponding under representation of African American, Asian/Pacific Islander and Hispanic students. This slight imbalance is rectified in the data analysis when responses are weighted.

Table 2.3: COMPARISON OF SCHOOL ENROLLMENT[1] AND NUMBER OF RESPONDENTS BY GENDER

Gender	Grade								Total	
	6th		8th		10th		12th			
	State	MAS	State	MAS	State	MAS	State	MAS	State	MAS[2]
Males	51.4%	50.0%	50.8%	49.1%	50.7%	47.9%	48.9%	48.7%	50.5%	49.0%
	34,609	3,807	32,842	3,568	31,650	3,134	24,916	2,938	124,017	13,447
Females	48.6%	50.0%	49.2%	50.9%	49.3%	52.1%	51.1%	51.3%	49.5%	51.0%
	32,714	3,813	31,805	3,693	30,760	3,414	26,046	3,100	121,325	14,020
Total	67,323	7,620	64,647	7,261	62,410	6,548	50,962	6,038	245,342	27,467

[1]SOURCE: Maryland Public School Enrollment By Race/Ethnicity and Gender and Number of Schools, September 30, 2000: MSDE

[2] 237 respondents did not provide information on gender

QUESTIONNAIRE

The survey consisted of three questionnaire forms. Form One was designed for administration to sixth graders, Form Two for eighth and tenth graders, and Form Three for twelfth graders. All three forms included sections on students' background characteristics, drug knowledge, attitudes, and use patterns; family relationships; drug availability; and perceived safety. In addition, students completing Forms Two and Three were asked about any negative effects they had experienced from substance use; parental and peer approval of substance use; and estimates of degrees of risk associated with substance use. Twelfth graders completing Form Three were asked additional questions about alcohol, drugs, and driving. The 2001 MAS Forms One, Two and Three are included in Appendix B.

Table 2.4: COMPARISON OF SCHOOL ENROLLMENT[1] AND NUMBER OF RESPONDENTS BY RACE/ETHNICITY

Race/Ethnicity	Grade								Total	
	6th		8th		10th		12th			
	State	MAS	State	MAS	State	MAS	State	MAS	State	MAS[2]
African American	37.0%	23.4%	36.1%	23.5%	35.6%	20.7%	32.7%	21.3%	35.5%	22.3%
	24,927	1,735	23,314	1,663	22,196	1,318	16,644	1,258	87,081	5,974
Asian/Pacific Islander	4.1%	2.8%	4.4%	3.1%	4.7%	4.0%	5.0%	3.7%	4.5%	3.4%
	2,790	208	2,859	221	2,940	253	2,564	216	11,153	898
Hispanic	4.6%	2.5%	4.2%	2.5%	4.0%	3.0%	3.7%	2.2%	4.2%	2.6%
	3,113	189	2,699	178	2,492	189	1,882	130	10,186	686
White	53.9%	68.9%	55.0%	69.8%	55.4%	71.3%	58.3%	72.2%	55.5%	70.5%
	36,271	5,113	35,553	4,940	34,572	4,548	29,722	4,266	136,118	18,867
American Indian	0.3%	2.3%	0.3%	1.0%	0.3%	1.1%	0.3%	0.7%	0.3%	1.3%
	222	173	222	72	210	69	150	40	804	354
Total	67,323	7,418	64,647	7,074	62,410	6,377	50,962	5,910	245,342	26,779

[1]SOURCE: Maryland Public School Enrollment By Race/Ethnicity and Gender and Number of Schools, September 30, 2000; MSDE

[2] 925 respondents either did not respond to race/ethnicity or provided multiple responses; they are excluded from the table

The questions comprising the 2001 MAS were identical to the 1998 MAS. Unlike the 1998 MAS, the 2001 MAS was printed on scannable sheets to facilitate the transmission of data from the paper-and-pencil instrument into an electronic format for analysis. As a result, the respondents were asked to *darken a circle* to indicate their answer rather than *place an X* next to their response choice as was done in previous MAS administrations.

ADMINISTRATION PROCEDURES

In each participating school, questionnaires were administered in the classes that were identified by sampling procedures. Most surveys were administered on April 4, 2001. Some schools had scheduling conflicts on that day and elected to administer the MAS near but not on April 4, 2001. Previously, the MAS was conducted in December, midway through the academic year. The 2001 administration being in April instead of December suggests that on average the students participating in the 2001 survey are four months older than the same grade students in previous years.

Questionnaire packets were distributed to each participating school point of contact with instructions as to which classes were selected for the survey. The school point of contact distributed the materials, which contained forms, pencils, administration instructions, and return FedEx envelopes to the designated survey administrator (teachers or others) for each class. The 2001 MAS materials are located in Appendix C.

In most cases, teachers administered the questionnaire. In a few instances, other school personnel administered questionnaires. Survey administrators were responsible for requesting student participation, distributing forms, delivering instructions, and returning the collected

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questionnaires to the school point of contact. In addition, they were instructed to assure students of the voluntary nature of their participation and the confidentiality of their responses.

In each classroom, the questionnaires were collected from the students by one of the participants, placed in a large envelope, and sealed in order to assure respondents' confidentiality and protect their privacy. School points of contact were instructed to return all survey forms (completed and blank) via FedEx to a designated survey repository site.

GENERALIZING THE SURVEY RESULTS

As described earlier in this chapter, the survey sample allows generalization of responses at the school system level. Johnston, O'Malley, and Bachman (1999)[2], in their report of the national survey results on drug use from the *Monitoring the Future Study,* found that survey results, such as those from the MAS, represent an accurate estimate of drug use, despite the fact that the estimates rely on self-reported measures of drug use. They believe there is a "high level of validity" in the measures obtained.

Johnston, O'Malley, and Bachman also discuss whether the twelfth grade findings can be generalized to "dropouts" (students who do not finish high school). While many have hypothesized that dropouts use drugs more than students who stay in school, these researchers for the Monitoring the Future study found that the increased use by dropouts theory does not always hold true. They conclude however, that until such time as good trend data are gathered directly from dropouts, estimates on incidence and prevalence of drug use among the school aged population are limited to students who are in school and participate in the survey. The MAS results, therefore, are only generalizable to those students who are in school.

AN IMPORTANT NOTE REGARDING 12-MONTH USAGE

Nearly all students who report that they have used a substance in the last 30 days also report using it in the last 12 months too. A few students, however, who report that they used the substance in the last 30 days, left the 12-month usage question blank. In 1998, the 12-month question was kept blank if a student did not answer this question. In the 2001 MAS, however, these two variables were recoded (when necessary) to make the 30-day and 12-month usage questions correspond. For the 2001 MAS, if a student reports using a substance in the last 30-days and they left the 12-month usage question blank, their 12-month usage question will be recoded to indicate that they did use the substance within the past year. As a result of this recoding, 2001 MAS 12-month usage may be elevated compared to corresponding values in the 1998 MAS. This change in the coding procedure should be kept in mind when comparing 12-month usage from 1998 to 2001.

[2] Johnston, L.D., P.N. O'Malley, and J.G. Bachman. 1999. National survey results on drug use from the *Monitoring the Future Study,* 1975-1998: Volume 1, secondary school students. Washington, D.C.: National Institute on Drug Abuse, U.S. Department of Health and Human Services.

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2001 MARYLAND ADOLESCENT SURVEY:
Summary of Results for Montgomery County Public Schools

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September 2001

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2001 MARYLAND ADOLESCENT SURVEY[1]
Summary of Results for Montgomery County Public Schools

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Background

The purpose of the Maryland Adolescent Survey (MAS) is to provide educators and related public service providers estimates of substance abuse among adolescents. The survey content and methodology parallel those of the annual national study, Monitoring the Future, conducted by the University of Michigan's Institute of Survey Research Center. The most recent Maryland Adolescent Survey was administered to Maryland public school students during the spring of 2001. During late September, the Maryland State Department of Education (MSDE) will release findings of the 2001 Maryland Adolescent Survey to the general public. The findings describe state trends over time and compare state results to national results.

The 2001 MAS also provides information about the substance abuse among students at the school district level. In spring 2001, 1,724 Montgomery County Public Schools (MCPS) students in grades 6, 8, 10 and 12 completed surveys, representing an 84% completion rate of students sampled. This report summarizes survey results relating to MCPS.

Summary of Findings

The summary below reports trends in drug use among MCPS students from 1996 to 2001 and describes how these trends compare with state and national trends. Table 1 displays percentages of MCPS students who said that they used various drug substances. Data are reported for the 2001, 1998, 1996, and 1994 surveys by frequency-of-use categories (i.e., ever used, used in last 30 days, and used in last year) for grades 6, 8, 10, and 12. Table 2 reports data for students in Maryland public schools. The Technical Appendix at the end of this summary details the sampling procedure, completion rates, and approximate precision estimates ("error rate") for the reported percentages.

[1] The MAS Survey was administered to students in spring 2001. Surveys administered during previous years (1994, 1996, and 1998) were administered in the fall of the year.

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General Observations

2001 survey results showed several general trends.

- Most frequently used substances reported by MCPS adolescents in 2001 were: beer, wine, and wine coolers; liquor (rum, vodka, and whiskey), and cigarettes. One-half or more of the MCPS 12th grade students reported having ever used these substances, and about one-third of the MCPS 12th grade students reported having used these substances in the last 30 days.

- From 1998 to 2001, use of cigarettes, beer, wine, wine coolers, and liquor dramatically decreased among MCPS 10th and 12th grade students. These decreases continued downward trends observed in 1998.

- Fewer MCPS 10th and 12th grade students reported binge drinking (five or more drinks on the same occasion) in 2001 than in 1998.

- Many students continued to experiment with marijuana. In 2001, 29% of the MCPS 10th grade students and 43% of the MCPS 12th grade students replied that they ever used marijuana. This use, however, has remained generally the same for several years.

- From 1998 to 2001, use of designer drugs (e.g., MDMA, Ecstasy) among 10th and 12th grade students statewide has increased. Although not statistically significant, this trend was observed locally. More specific results are summarized below.

Specific Results

- **Decreased self-reported use of cigarettes from 1998 to 2001.**

  -- Fewer MCPS students in grades 8, 10, and 12 reported smoking cigarettes in 2001 than in 1998. Fewer MCPS 6th grade students also reported having smoked cigarettes, though the decline in percentages did not reach traditional levels of statistical significance.

  -- The decrease in the use of cigarettes was substantial. For example, in the category of "Ever Used," there were 8% fewer MCPS 8th grade students, dropping from 25% in 1998 to 17% in 2001; there were 15% fewer MCPS 10th grade students, dropping from 44% in 1998 to 29% in 2001; and there were 9% fewer MCPS 12th grade students, dropping from 49% in 1998 to 40% in 2001.

  -- The decrease in the use of cigarettes was also observed statewide, but the decline in percentages was not as great as those observed in Montgomery County.

-- Nationally, cigarette use has decreased slightly from 1994 to 2001, from 34% who smoked cigarettes in the last 30 days among 12th grade students in 1994 to 31% in 2001 (from Monitoring the Future: 1999-2000 cited by the Maryland Adolescent Surveys: 1990-2001 report).

- **Decreased self-reported use of alcohol from 1998 to 2001.**

  -- Fewer MCPS 10th and 12th grade students reported use of beer, wine, wine coolers, and liquor in 1998 than in 2001. Decreased use was also evident among MCPS 6th and 8th grade students, although the decline of percentages was not statistically significant.

  -- The decrease in the use of alcohol was substantial. For example, in the category of "Used in the Last 30 Days," there were 10% fewer MCPS 10th grade students, dropping from 35% in 1998 to 25% in 2001; and there were 7% fewer MCPS 12th grade students, dropping from 46% in 1998 to 39% in 2001.

  -- Decreased use of alcohol was also observed statewide, but the decline was primarily among 10th grade students.

  -- Nationally, alcohol use has remained about the same since 1994 -- about 50% of 12th grade students used alcohol in the last 30 days (from Monitoring the Future: 1999-2000 cited by the Maryland Adolescent Surveys: 1990-2001 report).

- **Decreased self-reported "binge drinking" (or drinking more than 5 drinks on the same occasion) from 1998 to 2001.**

  -- Fewer MCPS 10th and 12th grade students reported binge drinking in 2001 than in 1998.

  -- Five percent fewer MCPS 10th grade students reported ever binge-drinking, dropping from 34% in 1998 to 29% in 2001. Seven percent fewer MCPS 12th grade students reported ever binge-drinking, dropping from 51% in 1998 to 44% in 2001. Finally, fewer MCPS 6th grade students reported binge drinking more recently, although this decrease was not statistically significant.

  -- Decreased binge drinking was also evident statewide, but the decline was mostly among 8th and 10th grade students.

- **No change in use of other drugs.**

  -- Self-reported uses of other substances among MCPS students remained about the same across the two time periods. For many of these substances, 2% or less of the students reported having used these drugs. These drugs included: Methamphetamines, PCP, other hallucinogens, narcotics, barbiturates, crack, and other forms of cocaine.

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-- MCPS students reported similar use of marijuana in 1998 and in 2001. Many students had experimented (responded in the category of "Ever Used") with marijuana: 43% of MCPS 12th grade students and 29% of MCPS 10th grade students.

- **Use of designer drugs increased statewide and this trend was observed locally.**

  -- Statewide, more 10th and 12th grade students reported having used designer drugs (e.g., MDMA, Ecstasy) in 2001 than in 1998. Use of designer drugs was up 2 to 3% among 10th grade students and up 5 to 6% among 12th grade students.

  -- A similar trend, although not statistically significant, was observed in MCPS. Eight percent of the MCPS 10th grade students and 10% of the MCPS 12th grade students reported ever having used designer drugs. These percentages were up 3% to 4% up from two years past.

Technical Appendix

Who Does the Sample Represent?

The number of students in Maryland public schools who responded to the 2001 MAS was approximately 27,614 of 34,517 sampled students, representing an 80% completion rate statewide. Of these, 1,724 were MCPS students. Of the sampled MCPS students, 84% completed the survey.

What is the Precision Estimate or "Error Rate" for Percentages?

The precision estimate for the entire MCPS respondent sample is + or - 2.5%, based on a 95% confidence interval. This means: If the survey were conducted 100 times, then in 95 of those 100 surveys, the true population percentage for any survey question would be expected to be plus or minus 2.5 percentage points of results provided by the present survey. Below appears a summary of the number of MCPS students who were sampled, completed surveys by grade level, and approximate precision estimates or expected "error rate" for percentages reported by each grade level.

Grade	Number of Schools	Number Classes	Number of Students Sampled	Number of Students Returned	Precision Estimate or "Error Rate"
6	9	18	466	428	+/- 4.7%
8	9	18	482	442	+/- 4.7%
10	9	22	517	438	+/- 5.7%
12	9	21	545	416	+/- 4.8%
Total	36	79	2,010	1,724	+/- 2.5%

How Were Statistically Significant Results Determined?

A statistical z-test between differences in proportions was used to determine which of the percentages from 1998 and 2001 likely represented true differences. Variances were assumed to be maximum, where $p = 0.50$ and $q = 0.50$ and their product = 0.25. For MCPS year-to-year grade-level comparisons, the N for each year was assumed to be approximately 430, and for state year-to-year grade-level comparisons, the N for each year was assumed to be approximately 7,000.

Table 1

Montgomery County: Percentage of Self-reported Frequency of Substance Use Among Students in 6th, 8th, 10th, and 12th Grades

Substance	Grade Level 6 Ever Used	6 Last 30 Days	6 Last Year	8 Ever Used	8 Last 30 Days	8 Last Year	10 Ever Used	10 Last 30 Days	10 Last Year	12 Ever Used	12 Last 30 Days	12 Last Year
Cigarettes												
2001	3.0	0.8	1.3	↓ 17.2	6.4	↓ 10.2	↓ 29.0	↓ 11.4	↓ 17.9	↓ 40.1	↓ 21.1	↓ 26.2
1998	6.2	2.2	4.1	↓ 24.6	11.5	↓ 16.9	↓ 44.4	↓ 22.5	↓ 29.4	↓ 49.0	↓ 27.7	↓ 37.0
1996	7.2	1.8	3.6	31.8	14.6	22.6	36.9	19.7	26.8	56.4	33.6	43.0
1994	7.9	1.3	4.1	38.5	19.3	30.2	44.7	23.2	31.2	56.7	29.8	41.2
Smokeless tobacco (chewing tobacco, snuff, school)												
2001	0.5	0.3	0.3	3.1	1.9	2.6	2.7	1.0	1.8	6.7	2.7	4.4
1998	2.1	0.9	1.5	3.7	2.1	2.1	6.9	3.5	4.5	8.9	3.5	5.5
1996	1.7	0.5	0.7	6.2	2.4	4.1	6.2	2.8	3.5	16.7	4.6	9.6
1994	1.1	0.8	1.1	7.7	4.0	6.1	6.0	2.1	3.5	14.5	3.8	9.4
Beer, wine, wine coolers												
2001	5.5	2.3	3.6	28.5	14.3	25.1	48.8	↓ 24.7	↓ 42.9	↓ 63.7	39.5	↓ 57.0
1998	8.7	4.4	7.2	29.9	16.5	24.9	54.9	↓ 34.7	↓ 48.4	↓ 67.6	46.0	↓ 62.7
1996	13.7	6.4	11.8	36.2	20.3	32.7	50.0	32.3	47.0	75.0	51.5	69.7
1994	13.1	6.7	8.9	43.3	25.8	38.3	57.9	36.6	51.6	72.7	49.0	66.3
Liquor (rum, vodka, whiskey)												
2001	3.1	0.7	2.1	16.5	8.1	13.8	↓ 37.8	↓ 19.6	35.3	↓ 55.2	35.3	↓ 49.3
1998	4.4	1.8	4.0	16.9	9.6	14.8	↓ 46.4	↓ 30.2	41.3	↓ 62.2	37.2	↓ 56.3
1996	5.1	2.1	4.2	23.8	12.2	22.7	38.1	25.6	35.9	65.2	38.1	58.6
1994	5.1	2.5	3.8	31.5	17.9	27.4	38.9	22.6	34.3	60.9	34.0	55.2
Five or more servings of alcohol on same occasion												
2001	3.6	2.3	3.3	10.9	5.8	8.2	28.9	↓ 16.6	26.7	44.1	27.5	↓ 37.2
1998	4.4	2.9	3.1	13.0	7.5	9.7	33.5	↓ 23.6	29.8	↓ 50.7	31.3	↓ 45.7
1996	3.7	1.2	2.9	14.2	7.7	11.5	29.0	16.6	26.1	56.2	35.5	50.0
1994	4.4	2.1	3.2	18.5	12.9	16.8	30.7	18.6	28.0	49.9	30.4	44.8

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↓ Indicates percentages to right of arrow represent a statistically significant change from 1998 to 2001. Data from 2001, 1998, 1996, and 1994 Maryland

Table 1 (continued)

Montgomery County: Percentage of Self-reported Frequency of Substance Use Among Students in 6th, 8th, 10th, and 12th Grades

Substance	Grade Level 6 Ever Used	6 Last 30 Days	6 Last Year	8 Ever Used	8 Last 30 Days	8 Last Year	10 Ever Used	10 Last 30 Days	10 Last Year	12 Ever Used	12 Last 30 Days	12 Last Year
Marijuana (pot or grass) or Hashish												
2001	1.8	0.2	1.0	11.7	6.8	10.3	28.8	15.7	25.3	43.1	22.0	35.0
1998	1.5	0.8	1.5	12.8	8.0	11.6	29.8	18.3	25.6	41.9	23.4	35.5
1996	1.9	0.6	1.9	13.6	6.6	12.0	26.1	14.9	23.1	47.8	29.2	41.8
1994	0.9	0.9	0.9	14.1	9.8	13.6	28.4	19.0	25.4	41.2	26.8	37.1
Amphetamines (prescription diet pills, bennies, pep pills, uppers)												
2001	0.2	0.0	0.0	4.8	1.8	4.2	4.9	3.3	4.4	8.7	3.2	6.5
1998	1.1	0.4	1.1	4.2	2.6	3.4	2.9	1.5	2.3	7.5	3.1	5.5
1996	0.7	0.0	0.3	3.1	1.8	2.6	8.5	2.7	6.7	12.6	4.1	9.5
1994	0.3	0.3	0.3	5.0	2.6	4.8	2.9	1.3	2.5	7.5	5.5	7.5
Methamphetamines (meth, speed, crank, ice)												
2001	0.0	0.0	0.0	3.5	0.7	3.3	1.6	0.7	1.6	1.9	0.4	1.1
1998	1.1	0.6	1.1	2.4	1.2	2.0	4.5	2.1	4.1	4.8	2.2	3.8
1996	1.4	0.3	1.0	3.5	1.8	2.8	4.2	2.3	3.5	7.5	3.0	5.4
1994	0.6	0.6	0.6	3.7	2.4	3.2	1.9	1.6	1.9	4.4	2.4	4.4
LSD (acid)												
2001	0.3	0.3	0.3	3.7	2.4	3.4	2.4	1.6	2.4	7.9	1.2	6.1
1998	1.2	0.7	1.2	2.5	1.6	1.6	5.6	2.1	4.0	10.2	3.6	7.1
1996	0.3	0.0	0.0	4.2	2.2	4.0	8.4	5.4	7.8	15.6	6.3	12.9
1994	0.6	0.6	0.6	5.4	3.6	5.2	7.8	3.2	7.8	9.0	4.2	8.7
PCP (angel dust, love boat, green)												
2001	0.3	0.3	0.3	2.7	1.7	2.2	2.5	2.0	2.0	2.1	0.7	1.4
1998	0.8	0.7	0.8	4.0	2.9	3.1	3.7	1.4	2.3	5.3	1.7	3.1
1996	1.1	0.3	0.6	1.4	1.0	1.4	5.0	2.6	3.4	9.1	1.9	6.3
1994	0.9	0.6	0.6	3.1	2.6	3.1	4.8	1.9	4.8	4.6	2.2	4.2

Table 1 (continued)

Montgomery County: Percentage of Self-reported Frequency of Substance Use Among Students in 6th, 8th, 10th, and 12th Grades

Substance	Grade Level											
	6			8			10			12		
	Ever Used	Last 30 Days	Last Year	Ever Used	Last 30 Days	Last Year	Ever Used	Last 30 Days	Last Year	Ever Used	Last 30 Days	Last Year
Other Hallucinogens (mescaline, 'shrooms)												
2001	0.3	0.3	0.3	3.2	2.2	3.0	3.8	2.8	3.8	6.2	1.9	3.3
1998	0.8	0.7	0.8	3.8	2.4	3.4	5.3	3.0	4.6	8.9	3.2	6.6
1996	0.5	0.0	0.5	2.4	2.0	2.4	4.0	4.0	4.0	14.2	7.0	12.9
1994	0.6	0.6	0.6	3.1	2.0	3.1	3.3	2.1	3.3	6.6	2.6	6.2
Narcotics Other Than Heroin (codeine, morphine, Darvon, Percodan, Dilaudid)												
2001	0.3	0.0	0.3	2.2	0.9	1.9	3.4	2.4	3.2	3.3	0.4	2.4
1998	0.8	0.6	0.8	1.0	1.0	1.0	2.6	2.0	2.6	6.2	2.5	5.0
1996	0.8	0.5	0.5	1.5	0.8	1.5	4.7	2.7	3.8	8.8	5.5	7.5
1994	0.3	0.3	0.3	2.0	0.5	1.4	2.2	1.6	2.2	3.8	2.2	3.0
Barbiturates or Tranquilizers (valium, downers, reds, dummies, yellows, goofballs, slammers)												
2001	0.3	0.3	0.3	1.2	0.7	0.9	2.3	1.0	2.3	0.7	0.3	0.7
1998	0.4	0.4	0.4	2.2	1.6	1.4	1.5	0.4	0.8	3.3	1.5	2.0
1996	0.7	0.1	0.3	1.5	1.1	1.5	3.2	1.8	3.0	7.1	3.8	6.2
1994	0.6	0.3	0.3	1.8	1.3	1.8	4.5	2.3	4.2	4.5	2.6	3.0
Crack (rock)												
2001	0.5	0.5	0.5	2.7	1.2	2.2	1.1	0.8	0.8	1.1	0.0	0.0
1998	0.8	0.8	0.8	3.5	2.6	3.0	3.5	1.9	2.7	4.1	3.0	3.7
1996	0.7	0.4	0.4	0.9	0.6	0.9	2.9	1.3	2.9	2.0	1.0	1.0
1994	0.6	0.6	0.6	2.6	1.8	2.1	1.3	1.0	1.0	1.7	1.2	1.5
Other Forms of Cocaine												
2001	0.2	0.2	0.2	2.1	1.2	1.7	1.5	1.0	1.5	2.6	0.4	0.8
1998	0.7	0.7	0.7	2.0	1.6	1.6	2.7	1.7	2.3	6.7	2.6	5.0
1996	0.9	0.0	0.5	1.1	0.4	1.1	3.1	1.4	2.5	6.8	1.5	5.0
1994	0.6	0.6	0.6	1.6	1.1	1.3	2.3	0.7	1.9	3.6	2.1	3.6

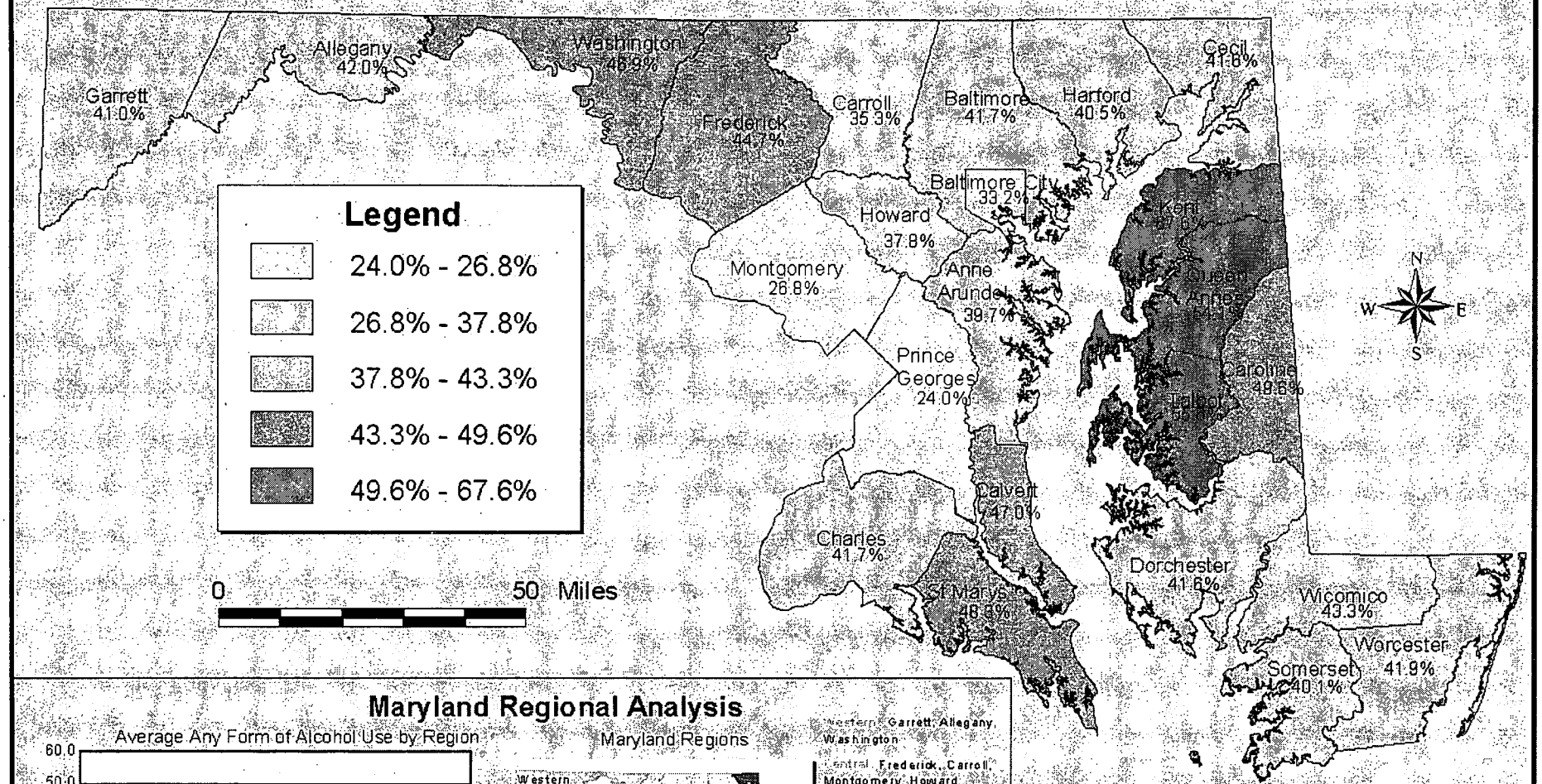
Table 1 (continued)

Montgomery County: Percentage of Self-reported Frequency of Substance Use Among Students in 6th, 8th, 10th, and 12th Grades

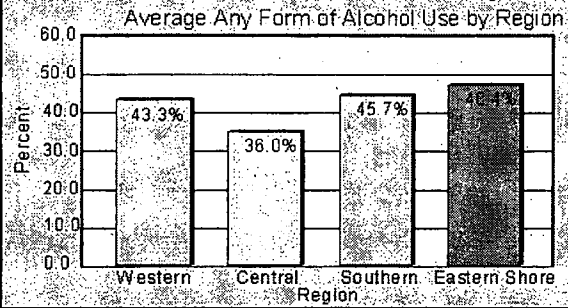
Substance	Grade Level											
	6			8			10			12		
	Ever Used	Last 30 Days	Last Year	Ever Used	Last 30 Days	Last Year	Ever Used	Last 30 Days	Last Year	Ever Used	Last 30 Days	Last Year
Steroids for Body Building												
2001	1.0	0.5	0.8	2.6	1.4	2.1	0.8	0.5	0.8	1.7	1.3	1.7
1998	0.6	0.4	0.6	2.3	1.5	1.9	1.1	0.7	0.7	2.0	1.5	1.8
1996	1.2	0.2	0.9	1.3	1.3	1.3	2.4	0.7	2.2	2.0	1.2	1.4
1994	1.4	0.8	1.1	1.1	1.1	1.1	1.9	1.2	1.5	1.0	0.8	0.8
Designer Drugs (MDMA, Ecstasy)												
2001	↑0.5	0.0	0.5	↑3.9	↑1.9	↑3.6	↑7.7	↑3.9	↑7.4	↑9.9	↑1.6	↑7.0
1998	↑0.4	0.4	0.4	↑1.8	↑0.8	↑1.2	↑4.2	↑3.4	↑4.2	↑5.6	↑2.8	↑4.7
1996	0.3	0.0	0.0	3.3	1.8	2.7	4.3	2.5	3.5	7.6	2.8	6.9
1994	0.6	0.6	0.6	3.3	2.5	3.3	4.1	2.2	4.1	3.7	2.1	3.7
Heroin (smack, stuff)												
2001	0.5	0.5	0.5	1.9	1.4	1.9	0.5	0.2	0.5	0.7	0.0	0.0
1998	0.4	0.4	0.4	2.7	1.8	2.0	1.5	1.5	1.1	2.5	1.5	2.3
1996	1.1	0.3	0.8	1.9	1.5	1.9	2.1	1.4	2.1	2.9	1.7	1.7
1994	0.4	0.4	0.4	1.5	1.2	1.5	2.3	1.3	2.0	1.5	0.9	1.5
Needle to Inject Cocaine, Heroin, of Some Other Illegal Drug												
2001	0.3	0.0	0.0	1.9	1.2	1.7	0.2	0.0	0.2	1.1	0.0	0.0
1998	0.6	0.6	0.6	2.0	1.2	1.5	0.5	0.5	0.5	2.0	1.3	1.8
1996	0.6	0.2	0.2	0.6	0.4	0.6	1.5	0.4	1.5	1.5	1.0	1.0
1994	0.4	0.4	0.4	1.5	1.2	1.5	2.1	1.3	1.6	0.5	0.5	0.5

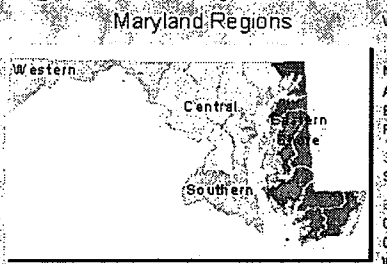
Maryland Adolescent Survey 2001

Percent of 10th Grade Students Reporting **Any Form of Alcohol** Use within the Last 30 Days



Maryland Regional Analysis





Western: Garrett, Allegany, Washington

Central: Frederick, Carroll, Montgomery, Howard, Anne Arundel, Baltimore, Baltimore City, Harford, Prince Georges

Southern: Charles, Calvert, St Marys

Eastern Shore: Cecil, Kent, Queen Annes, Talbot, Caroline, Dorchester, Wicomico, Somerset, Worcester

Source: Maryland Adolescent Survey 2001

Cartographer: Joe Sinatra

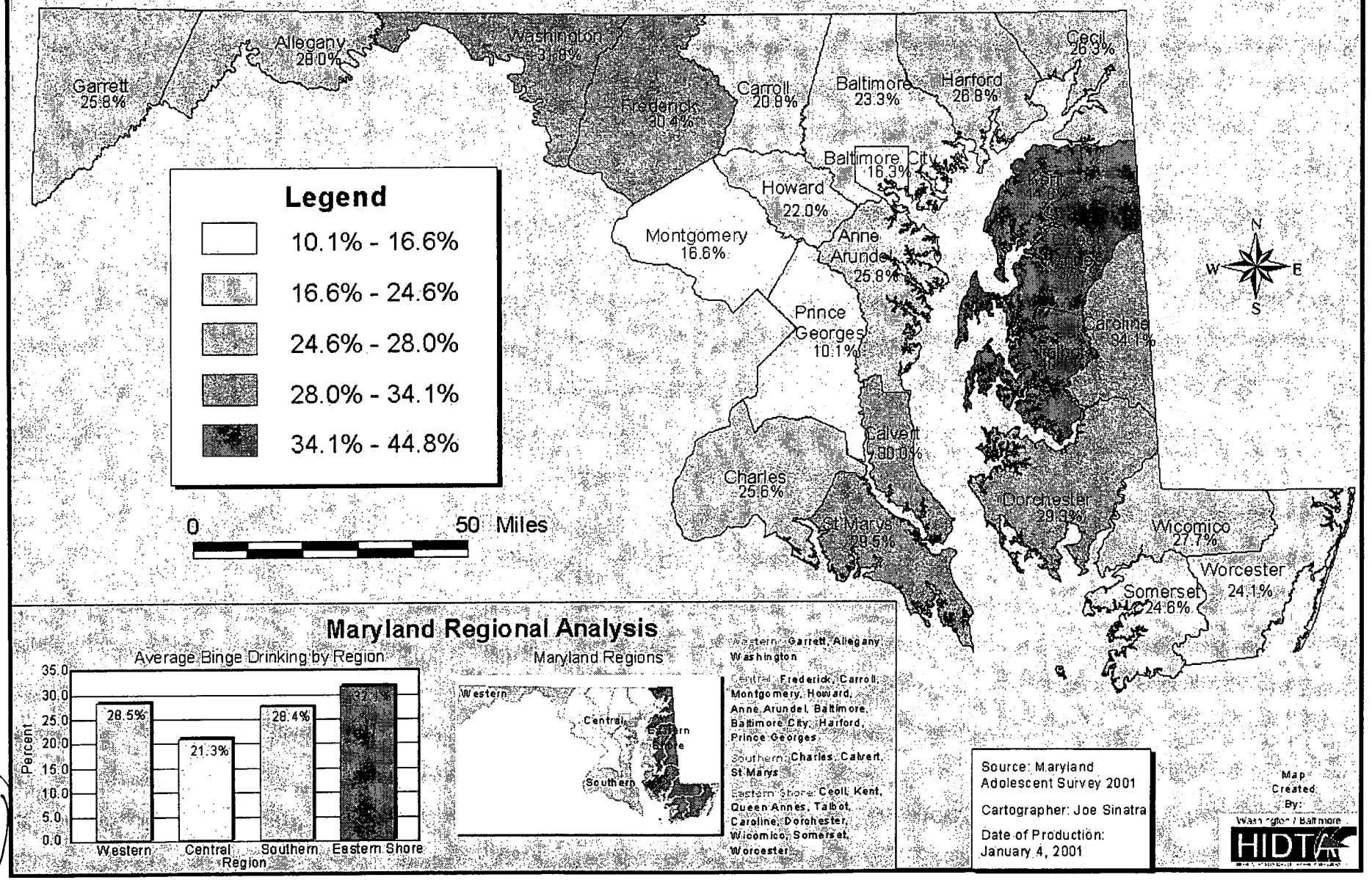
Date of Production: January 4, 2001

Map Created By: Washington / Baltimore HIDTA

9-1

Maryland Adolescent Survey 2001

Percent of 10th Grade Students Reporting **Binge Drinking** within the Last 30 Days



Maryland Regional Analysis

Western: Garrett, Allegany, Washington

Central: Frederick, Carroll, Montgomery, Howard, Anne Arundel, Baltimore, Baltimore City, Harford, Prince Georges

Southern: Charles, Calvert, St Marys

Eastern Shore: Cecil, Kent, Queen Annes, Talbot, Caroline, Dorchester, Wicomico, Somerset, Worcester

Source: Maryland Adolescent Survey 2001

Cartographer: Joe Sinatra

Date of Production: January 4, 2001

Map Created By:

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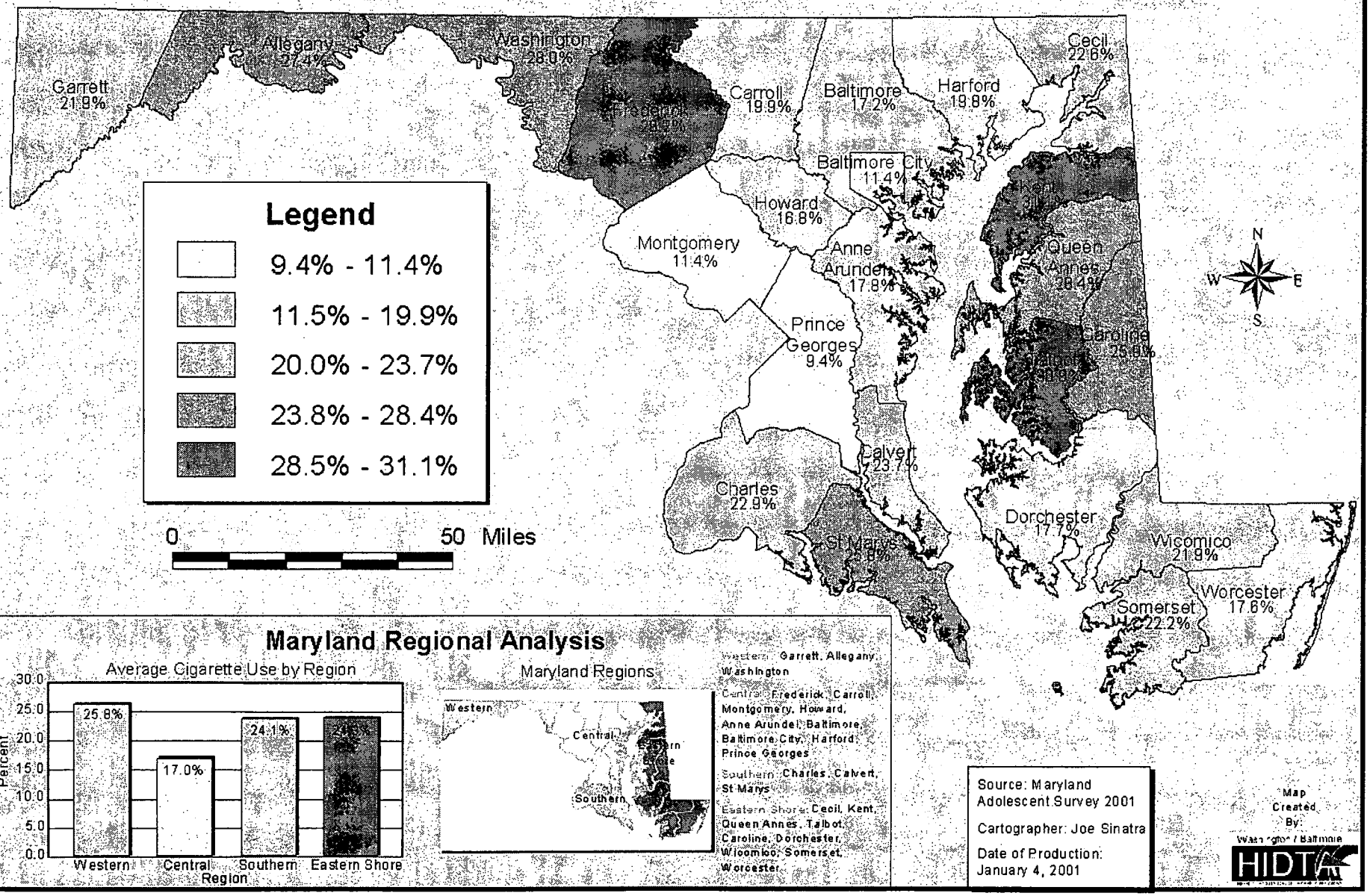
E-2

Maryland Adolescent Survey 2001

Percent of 10th Grade Students Reporting **Cigarette** Use within the Last 30 Days



Maryland Regional Analysis

Western: Garrett, Allegany, Washington

Central: Frederick, Carroll, Montgomery, Howard, Anne Arundel, Baltimore, Baltimore City, Harford, Prince Georges

Southern: Charles, Calvert, St Marys

Eastern Shore: Cecil, Kent, Queen Annes, Talbot, Caroline, Dorchester, Wicomico, Somerset, Worcester

Source: Maryland Adolescent Survey 2001

Cartographer: Joe Sinatra

Date of Production: January 4, 2001

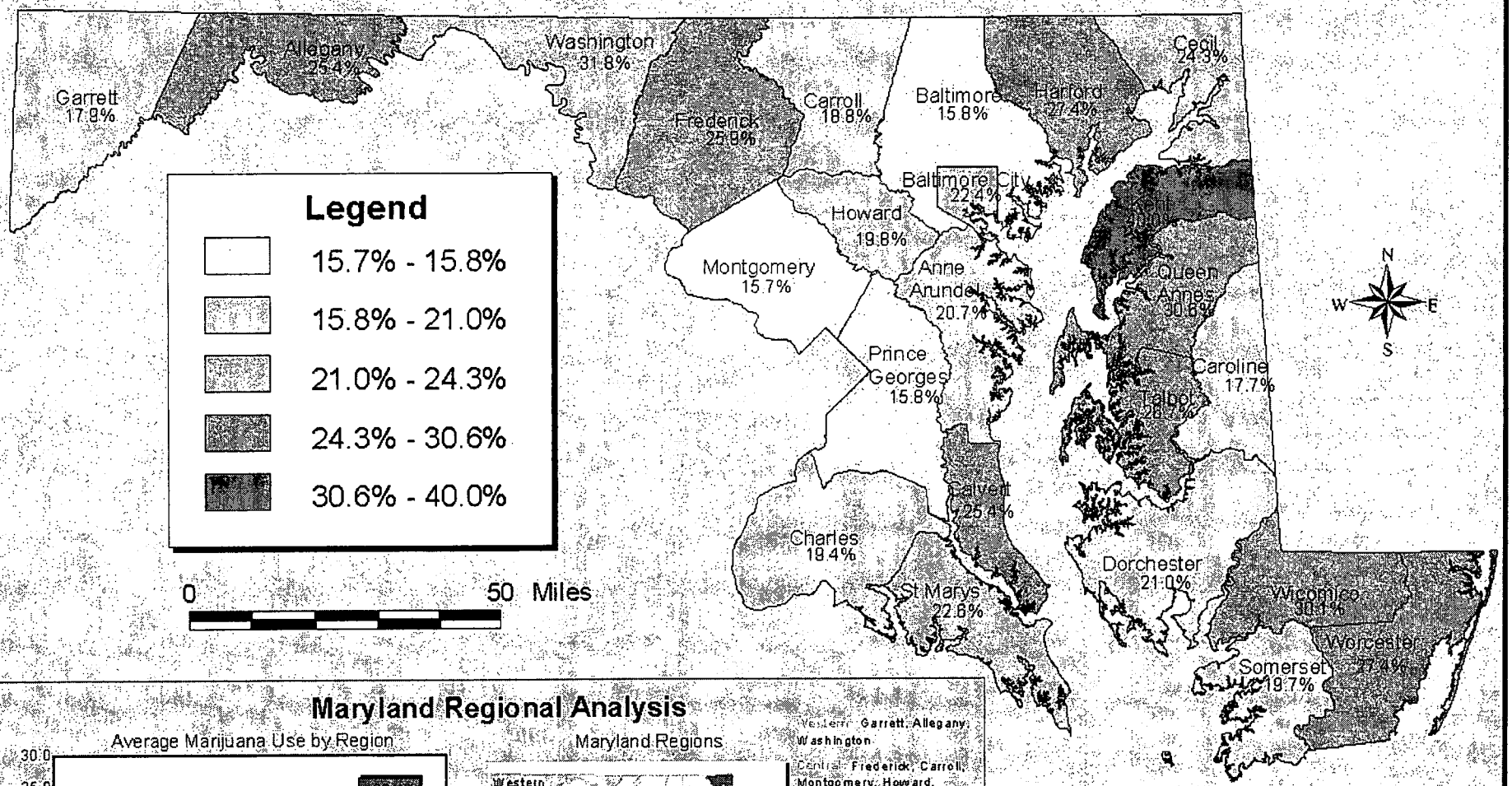
Map Created By:

HIDTA

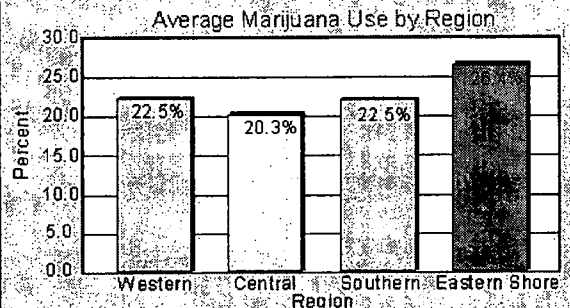
E-3

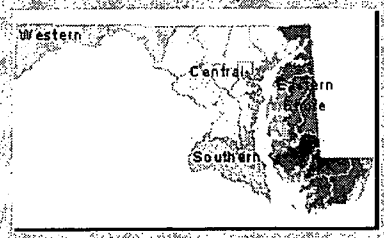
Maryland Adolescent Survey 2001

Percent of 10th Grade Students Reporting **Marijuana** Use within the Last 30 Days



Maryland Regional Analysis





Western: Garrett, Allegany, Washington

Central: Frederick, Carroll, Montgomery, Howard, Anne Arundel, Baltimore, Baltimore City, Harford, Prince Georges

Southern: Charles, Calvert, St Marys

Eastern Shore: Cecil, Kent, Queen Annes, Talbot, Caroline, Dorchester, Wicomico, Somerset, Worcester

Source: Maryland Adolescent Survey 2001

Cartographer: Joe Sinatra

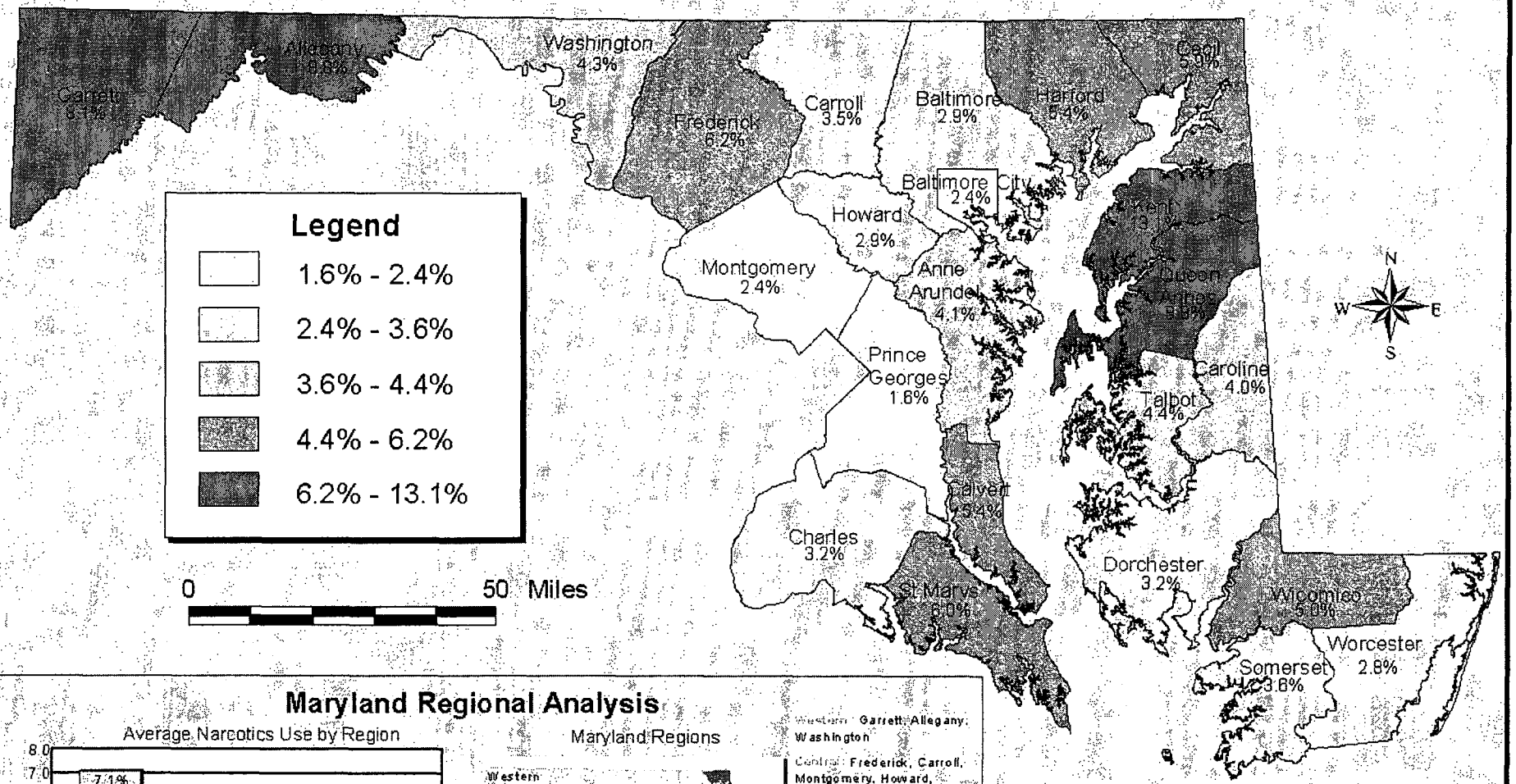
Date of Production: January 4, 2001

Map Created By: Washington / Baltimore HIDTA

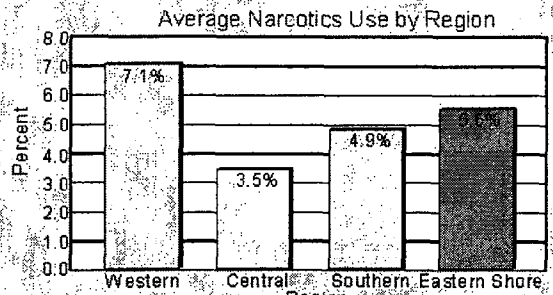
G-4

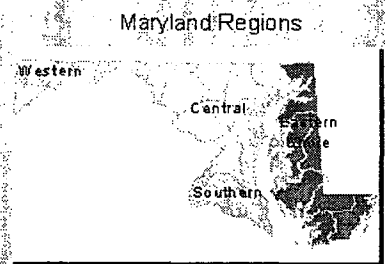
Maryland Adolescent Survey 2001

Percent of 10th Grade Students Reporting **Narcotics** Use within the Last 30 Days



Maryland Regional Analysis





Western: Garrett, Allegany, Washington

Central: Frederick, Carroll, Montgomery, Howard, Anne Arundel, Baltimore, Baltimore City, Harford, Prince Georges

Southern: Charles, Calvert, St.Marys

Eastern Shore: Cecil, Kent, Queen Annes, Talbot, Caroline, Dorchester, Wicomico, Somerset, Worcester

Source: Maryland Adolescent Survey 2001

Cartographer: Joe Sinatra

Date of Production: January 4, 2001

Map Created By:

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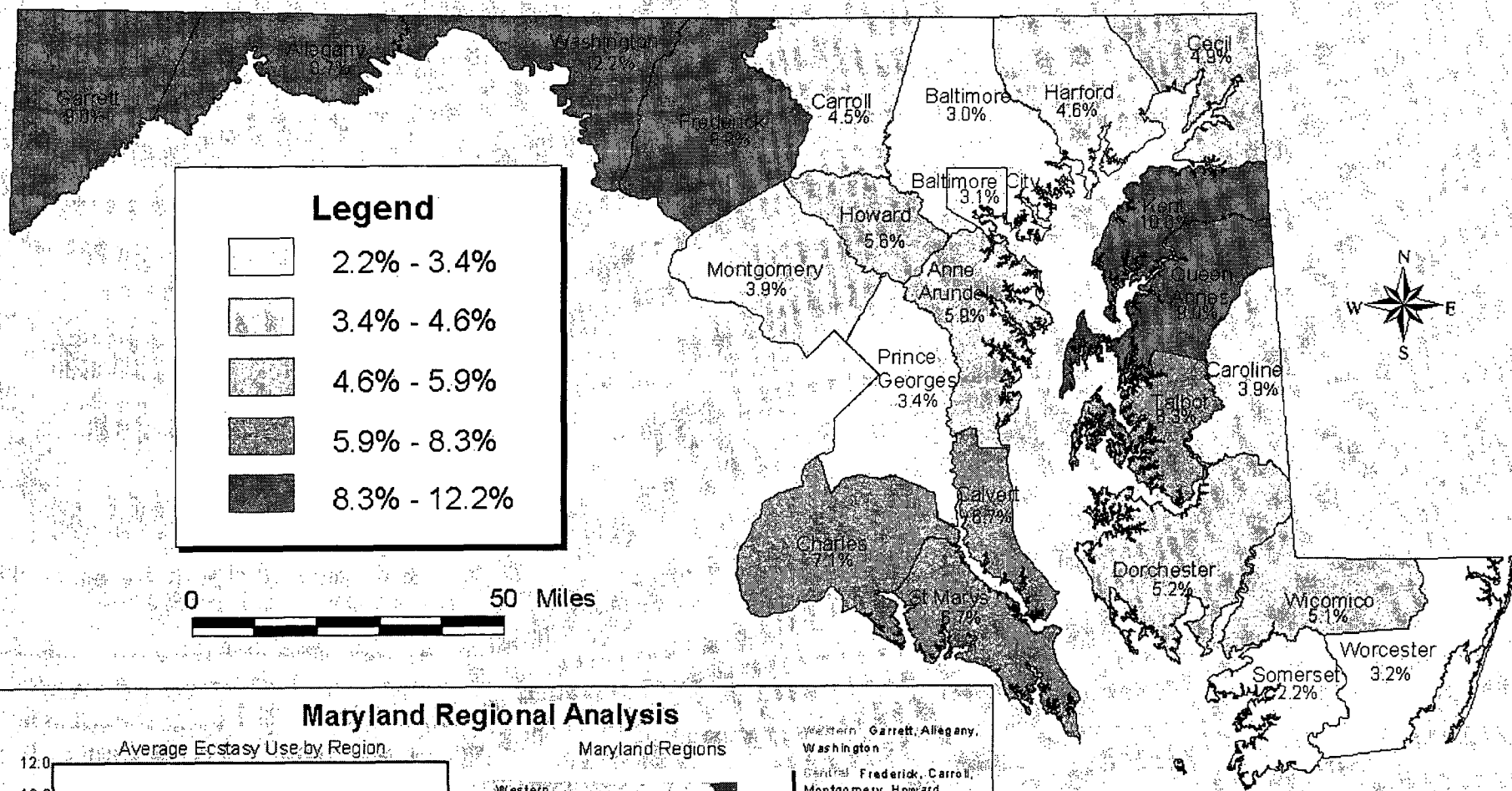
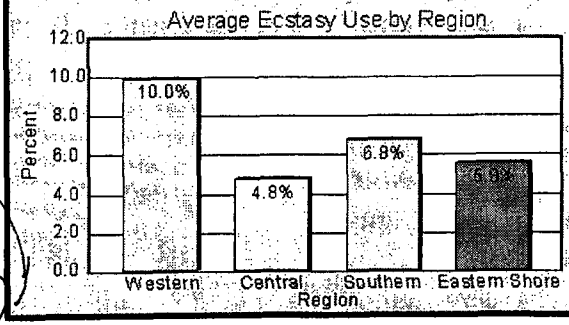
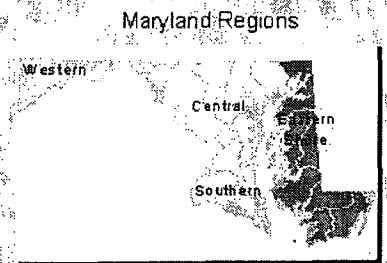
Maryland Adolescent Survey 2001

Percent of 10th Grade Students Reporting **Ecstasy** Use within the Last 30 Days



Maryland Regional Analysis





Western: Garrett, Allegany, Washington

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Eastern Shore: Cecil, Kent, Queen Annes, Talbot, Caroline, Dorchester, Wicomico, Somerset, Worcester

Source: Maryland Adolescent Survey 2001

Cartographer: Joe Sinatra

Date of Production: January 4, 2001

Map Created By: Washington / Baltimore HIDTA

G-6

What Scientists Know About Prevention

To synthesize and disseminate information about substance abuse prevention, CSAP relies on scientific knowledge. Science-based knowledge accrues from research findings that, for CSAP's purposes, inform the understanding and reduction of substance abuse in America. The field has changed dramatically in the past three decades; in the last year alone, significant new findings have emerged to direct efforts to prevent substance abuse in America.

Research in the field of substance abuse has focused on two interrelated areas: risk factors and protective factors. Both involve attitudes, behaviors, beliefs, and actions; but they are very different. *Risk factors* increase an individual, a group, or a community's vulnerability to substance abuse. *Protective factors* build a resiliency in the same individual, group, or community and increase the likelihood that they will successfully resist substance abuse and its related effects.

Scientists have determined that both risk and protective factors are critical components of substance abuse prevention and must be fully understood, but neither alone provides all the answers. Risk factors and protective factors are woven together in a tight, interactive web, and prevention programs must build on the body of knowledge that exists in both areas of study.

Further, research has revealed that the interactive web of risk and protective factors extends across all areas of our lives; one model constructs seven "domains," or life areas—each with its own risk and protective factors. Those seven domains are individual, peer, family, school, community, workplace, and society.

Researchers report that prevention programs can achieve positive outcomes in one or more domains. When these outcomes are achieved, the result is that substance abuse is delayed, reduced, or prevented altogether. With that knowledge, prevention programs today target more than one domain as a means of leveraging the positive outcomes and extending their benefit. Researchers also recommend multiple interventions, which, if science-based, often can enhance the outcomes achieved.

With science as the foundation, prevention programs can take advantage of insights like these and further evaluate prevention programs to determine which are the most effective.

The rise in the past 25 years of the theory of resilience is a clear example of the impact that science-based prevention programs can have. Researchers identified and then studied the notion that "resilient" individuals—those with a specific set of learned characteristics—are better able to resist destructive behaviors, including substance abuse. Researchers noticed that this resiliency protected individuals even when they were surrounded by risk factors such as poverty, parents who were substance abusers, or a dysfunctional family. Over a quarter century, the research into the theory of resiliency has named the characteristics of resilient people, noted that they are learned behaviors, and evaluated prevention programs that teach these behaviors to people who are exposed to risk factors in one or more of their domains. Because resiliency also takes hold across domains, the science-based programs that teach these skills have a direct and lasting impact on reducing and preventing substance abuse.

The list that follows briefly highlights recent and existing scientific knowledge about the relationship between these life domains and risk and protective factors for substance use. This knowledge continues to grow; thus, the list is neither comprehensive, nor exclusive.

Risk and Protective Factors

The following is a review of recent and existing scientific knowledge about the relationship between life domains and risk and protective factors for substance use. The italicized text indicates new research.

Individual

- *The prevalence of alcohol and illicit drug use is seven to 10 times higher in smokers than in non-smokers.* [1]

- Youth who believe that cigarettes or drugs will cause them physical harm are less likely to smoke or use drugs.[2] Young people tend to be more concerned about the immediate effects of substance use than about the long-term effects.[3, 4, 5]

- Sensation seeking, a personality trait involving preferences for novel, unusual, or risky situations [6, 7, 8] *is linked with tobacco use* [9, 10] and drug and alcohol use.[11, 12, 13, 14, 15]

- *Young adults who experiment with alcohol and drugs before sex, have sex with different partners, and have inconsistent safe-sex practices, are at risk of HIV.* [16]

- Inappropriate expression of anger increases the chances of forming deviant peer associations and increases the chances of developing deviant norms around substance use and other risks.[17] Conduct disorders, anxiety, and aggression may be precursors of later drug use.[18, 19, 20, 21] Arrests for assault correlate with youthful substance abuse.[22]

- *Youths at highest risk are often not only frequent and heavy users of tobacco and alcohol, but are also poly-substance users and have high levels of problems in social functioning, criminal activity, psychological distress, physical health, HIV risk, and substance dependence.* [23]

- *Relative to HIV risk, young females are more likely than young males to have shared needles and had sex in exchange for drugs or money, with an HIV infected partner, and with an injection-drug user.* [24]

- *Co-morbid psychiatric and substance use diagnoses are attributed to adolescents with more behavior problems,* [25] *and functioning impairment.* [26] *Favorable treatment outcome of drug-abusing adolescents is two to three times more likely if treatment is completed than if it is not completed or if no treatment is received at all.* [27]

- Among boys especially, aggressive and disruptive classroom behavior predicts substance abuse.[28]

- *Differential treatment profiles between genders among adolescent substance abusers reveal that males report lower perceived family support, support from friends, incidents of residential treatment and truancy while females have high levels of depression, family support, support from friends, history of abuse, self-mutilation, past residential treatment, suicidality, and truancy. Additionally,*

Note: For the extensive list of footnote references in this section, please see the Appendix.

female profiles were lower than males in unusual harmful behavior (fire-starting and animal cruelty), all arrests except for sexual offense (prostitution), academic performance, and sexual activity.[29]

- *Smoking-attributable deaths create single-parent headed households, resulting in increased Social Security costs.*[30] *Smoking is the leading cause of residential and total fire deaths.*[31]

- Youth who have conventional values are less likely to abuse substances,[32] as are youth who value academic achievement more than independence.[33]

- Youth who possess a variety of social competencies or life skills resist substance abuse;[34] *whereas decisionmaking skills, personal efficacy, and beliefs about the negative benefits of smoking are important in preventing cigarette smoking.*[35]

- *Youth who engage in problem behaviors are at risk for using tobacco, alcohol, and other drugs.*[36, 37] *Such risk behaviors as rebelliousness are influential for smoking in both males and females.*[38, 39]

- Increased use of alcohol and marijuana at younger ages is related to riskier sexual activity and increased use of alcohol and marijuana as young adults.[40]

Family

- Poor parenting practices exacerbate antisocial behavior in childhood and adolescence and can predict adolescent substance abuse.[41, 42, 43] Children's substance use is also predicted by nonexistent or inconsistent parental discipline;[44, 45] whereas disciplinary techniques that include clear limit-setting and consistent rewards for positive behavior are associated with reduced substance use.[46, 47]

- *Low parent-child bonding is associated with substance use risk.*[48] *Bonding is of particular consequence for migrant families,*[49] along with perceived parent child communication in these families.[50, 51] Prevention programs that acknowledge and address differential family acculturation have produced positive effects.[52]

- Positive family dynamics are associated with positive bonding among family members,[53] and close and mutually reinforcing parent-child relationships are linked with less substance abuse.[54, 55, 56]

- Strong parent-child attachment leads to children's internalization of traditional norms and behavior, which in turn leads to less substance use and nonuse.[57]

- *Age,*[58] *increased family size,*[59] *parental smoking, sibling smoking, and living with a single parent are associated with regular active smoking in adolescents.*[60] *Parental substance abuse disorders also predict substance abuse in offspring during adolescence.*[61]

- Parental monitoring and supervision of children's activities and relationships protect against substance abuse.[62, 63, 64]

Note: For the extensive list of footnote references in this section, please see the Appendix.

- Besides such risk factors for substance use as age, psychosomatic status, and psychotropic drug consumption, at-risk youths also report an un-stimulating family atmosphere, living situations that do not include their mother and father, and negative perceptions of health; mothers who do not work outside the home may influence on protective influence on substance use among their adolescent children.[65]

School

- Poor school performance, absenteeism, prior drop-out status, and referrals from school personnel of youth at risk for drop-out, predict future truancy, drop-out, and drug involvement.[66, 67, 68, 69, 70, 71] Conversely, outstanding school performance can reduce the likelihood of frequent drug use,[72] and *engagement in school activities and sports, being drunk less frequently, and better family role models reduce the likelihood of future substance use.*[73]

- School bonding protects against substance abuse and other problem behaviors.[74]

- Negative, disorderly, and unsafe school climate can contribute to problematic developmental outcomes among students.[75]

- Teacher and student perceptions of firm and clear rule enforcement are linked with reduced school disorder, an outcome associated with substance nonuse.[76]

- A severe lag between chronological age and school grade places youths at risk for substance abuse.[77] Youth in alternative high schools face elevated risks of substance use.[78] Compared to public school students, those in private schools report higher rates of alcohol use, drunk driving, binge drinking, smoking, marijuana use, and drug-impaired sexual activity.[79]

- *Severe substance use is associated with higher likelihood of drinking at school with alcohol users more likely to drink at home or at a friends' house. Drug users were more likely to report substance use outdoors, at a friends' house, at parties, and at school.*[80]

- *Though many school-based prevention programs employ a social-influences approach based on cognitive-behavioral theory, new data call into question the efficacy of these approaches.*[81, 82]

Peers

- Peer substance use is among the strongest predictors of substance use,[83, 84, 85] a finding confirmed across ethnic-racial groups,[86, 87, 88, 89] though peer influences are weaker for black youth than for Latino or white youth.[90, 91] Across all groups, young people overestimate peer substance use.[91, 92, 93, 94, 95]

- *Peer pressure and peer conformity are stronger predictors of risk behaviors than measures assessing popularity, general conformity, or dysphoria.*[96]

Note: For the extensive list of footnote references in this section, please see the Appendix.

- Sustained involvement in structured peer activities, including extracurricular programs, is linked with low levels of drug use.[97, 98, 99, 100]

- Associating with deviant peers strongly predicts early substance use.[101, 102] Low acceptance by peers appears to place youth at risk for school problems and criminality, which are risk factors for substance abuse.[103, 104] Youth who are strongly peer-oriented or who have a strong external locus of control are vulnerable to substance use and other problem behaviors.[105]

- Peer involvement in intervention implementation and normative education appears critical.[106, 107, 108, 109]

Community

- Ready access to tobacco, alcohol, and other drugs increases the likelihood that youth will use substances[110, 111, 112, 113] *and among students, males specifically obtain tobacco over alcohol from commercial sources.*[114]

- *Monetary incentives to entice adolescents to participate in smoking-related community surveys increase response rates, but incentives do not adversely affect youths' willingness to participate in smoking cessation interventions.*[115]

- *Community-based, rural area interventions for HIV/AIDS prevention programs have a positive impact on adolescent sexual risk taking.*[116]

- Communities lacking resources are vulnerable to high rates of adolescent substance abuse.[117, 118, 119, 120, 121]

- Community awareness and media efforts can improve perceptions about the likelihood of apprehension, and reduce noncompliance.[122] Counter-advertising on their hazards reduces sales of cigarettes[123, 124] and their consumption;[125, 126, 127] whereas conspicuous labeling influences awareness and behavior.[128, 129, 130]

Environment

- The ability to purchase alcohol is related to consumption and problem behavior,[131, 132, 133, 134, 135, 136, 137] *whereas minority ethnic status*[138] *is related to increased ability to purchase cigarettes.*

- *The likelihood of smoking is increased among adolescents who own or are willing to use a cigarette promotional item; smoking initiation decreases when such items are lost or youths become unwilling to use the items.*[139]

- *Cigarette brand-specific magazine advertising influences brand market share, brand of initiation*

Note: For the extensive list of footnote references in this section, please see the Appendix.

among new smokers, brand smoked by current smokers, and the brand advertised, which attracts the most attention.[140] *Declines in cigarette promotions and advertising and increases in antismoking message awareness have been reported by some students.*[141]

- Though underage youth access to tobacco is widespread,[142, 142, 143, 144, 145, 146, 147, 148, 149] when merchants comply with bans against underage sales, purchase rates are commensurately lower.[150, 151]
- Neighborhood anti-drug strategies (e.g., citizen surveillance, nuisance-abatement programs), can dislocate dealers and reduce the number and density of retail drug markets while also lowering other crimes.[152, 153, 154, 155, 156, 157]
- Increasing the price of alcohol and tobacco through excise taxes reduces consumption[158, 159, 160, 161, 162, 163] and local tobacco sales ordinances reduce the likelihood of youths in becoming established smokers.[164]
- Raising the minimum purchase age for alcohol decreases use among youth,[165, 166] particularly related to beer consumption,[167] and lowers alcohol-related traffic accidents.[168, 169]

Workplace

- Adolescents who work more than 15 hours a week may face increased risk for substance abuse.[170]
- Stress in the workplace may modestly elevate alcohol consumption.[171, 172, 173]
- Alienation from work may increase employees' drinking behavior,[174, 175] though such findings have been challenged.[176, 177] Employee drug use is linked with job estrangement and alienation.[178]
- Occupations have widely varied drinking norms,[179] and heavy-drinking occupations attract employees prone to this.[180]
- When employers communicate company policy disapproving of substance use or abuse, workplace norms change,[181, 182] though lunchtime drinking in the workplace is fairly common.[183]
- Urine testing can identify job applicants who have used illegal drugs in the recent past.[184] Random drug testing is on the rise,[185] and enjoys substantial public support.[186]
- Worker hangovers impact on cognitive and motor functions, creating risks of impaired judgment, interpersonal conflict, and injuries,[187] but are a neglected contributor to job performance problems.[188, 189]

Note: For the extensive list of footnote references in this section, please see the Appendix.

Life Skills Training

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LifeSkills™ Training is a program that seeks to influence major social and psychological factors that promote the initiation and early use of substances. LifeSkills has distinct elementary (8 to 11 years old) and middle school (11 to 14 years old) curricula that are delivered in a series of classroom sessions over 3 years. The sessions use lecture, discussion, coaching, and practice to enhance students' self-esteem, feelings of self-efficacy, ability to make decisions, and ability to resist peer and media pressure. The LifeSkills program consists of three major components that address critical domains found to promote substance use. Research has shown that students who develop skills in these three domains are far less likely to engage in a wide range of high-risk behaviors. The three components each focus on a different set of skills:

- **Drug Resistance Skills** enable young people to recognize and challenge common misconceptions about substance use, as well as deal with peers and media pressure to engage in substance use.
- **Personal Self-Management Skills** help students to examine their self-image and its effects on behavior, set goals and keep track of personal progress, identify everyday decisions and how they may be influenced by others, analyze problem situations, and consider the consequences of alternative solutions before making decisions.
- **General Social Skills** give students the necessary skills to overcome shyness, communicate effectively and avoid misunderstandings, use both verbal and nonverbal assertiveness skills to make or refuse requests, and recognize that they have choices other than aggression or passivity when faced with tough situations.

Awards and Professional Acknowledgments

Model Program: Center for Substance Abuse Prevention, 1999
Model Program: Centers for Disease Control and Prevention
Model Program: Office of Juvenile Justice and Delinquency Prevention, 1998
Model Program: White House Office of National Drug Control Policy
Exemplary Program: U.S. Department of Education
Programs That Work: National Institute on Drug Abuse

How It Works

The LifeSkills Training curriculum for middle (or junior high) schools is intended to run for fifteen 45-minute class periods. A booster intervention has been developed that is taught over 10 class periods in the second year and five in the third year. This means the initial program should be implemented with sixth or seventh grade students, followed by booster sessions during the next 2 years. Optional violence prevention units can be implemented for each year of the program, extending the overall number of class sessions.

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The LifeSkills Training elementary school curriculum runs for 24 class sessions, each 30 to 45 minutes long, to be conducted over 3 years. The first year (i.e., Level 1) is composed of eight class sessions and covers all skill areas. The remaining booster sessions are divided into eight class sessions for Level 2 and eight for Level 3. The booster sessions provide additional skill development and opportunities to practice in key areas. Level 1 is designed for either grade three or four, depending on when the transition from elementary to middle school begins.

Both the elementary and middle school programs can either be taught intensively (consecutively every day, or two to three times a week) until the program is complete, or it can be taught on a more extended schedule (once a week). Both formats have proven to be equally effective.

Target Population

The LifeSkills program targets individuals who have not yet initiated substance use. It is designed to prevent the early stages of substance use by influencing risk factors associated with substance abuse, particularly occasional or experimental use. The program has been tested in urban and suburban schools with Caucasian, African-American, Hispanic, and Asian-American students in grades 7 through 12 (11 to 18 years old). An elementary school version of the LifeSkills program has been tested with students in grades 3 to 5 (8 to 11 years old).

Protective Factors

Protective Factors to Increase

Individual

- Social development, self-esteem, self-discipline
- Communication skills
- Decision making skills
- Problem solving skills
- Social skills
- Assertiveness and refusal skills
- Stress and anxiety management
- Goal setting, self-monitoring, self-reinforcement

Family

- Effective communication with parents and other family members

Peer

- Resistance to peer pressure
- Social skills

School

- Academic success
- Goal setting

Risk Factors

Risk Factors to Decrease

Individual

I-2

- First confrontation with illegal substances, tobacco, and alcohol
- Lack of self-control and assertiveness

Peer

- Pro-drug influences

Benefits

- Develops resistance to peer and media pressure to use substances
- Develops a positive self-image
- Develops decision-making and problem-solving skills
- Helps youth manage anxiety
- Fosters effective communication
- Builds healthy relationships
- Increases youths' self-confidence in social situations

Evaluation Design

Over the past 20 years, a dozen evaluation studies of the LifeSkills Training program have been conducted. Among these are:

- A randomized study tested the effectiveness of peer leaders as providers of LifeSkills training. The number of new smokers in the group that received training with the peer leader was compared with a control group. Results were corroborated by a saliva thiocyanate (SCN) analysis, where an increase in SCN levels is indicative of increased smoking.
- A randomized study compared alcohol use over the past month and degree of use by students who received LifeSkills training with use rates reported by a control group.
- The National Institute on Drug Abuse (NIDA)-funded a study of approximately 1200 seventh grade students (from predominantly white, middle-class families) in 10 suburban New York junior high schools. The study compared the proportion of students reporting marijuana use in the peer-led LifeSkills group and a group of students who received LifeSkills booster sessions with the rates reported in the control group.
- NIDA also funded a randomized study involving nearly 6,000 students from 56 middle schools. Students received the program in the seventh through ninth grades and follow-up data was collected at the end of the twelfth grade.

Outcomes

The outcomes relative to controls included the following:

- Reduced initiation of cigarette smoking by 75%, and 3 months after program completion, by 67%
- Reduced alcohol use by 54%, heavy drinking by 73%, and drinking to intoxication one or more times a week by 79%
- Reduced marijuana use by 71%, and weekly or more frequent use by 83%
- Reduced multiple drug use by 66%
- Reduced both long-term and short-term substance abuse
- Reduced pack-a-day smoking by 25%
- Decreased use of inhalants, narcotics, and hallucinogens by up to 50%

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Implementation Essentials

The LifeSkills program is a completely self-contained prevention curriculum. To implement the program, in addition to a LifeSkills-trained provider (teacher, counselor, or health professional), all that is required is a curriculum set consisting of a Teacher's Manual, Student Guide, and relaxation tape.

Provider training is available for individuals interested in conducting the LifeSkills program. All training is conducted by qualified trainers who are certified by National Health Promotion Associates, Inc. The provider training workshop is designed to:

- Teach the background, theory, and rationale for the LifeSkills program
- Familiarize participants with the program
- Teach participants the skills needed to conduct the LifeSkills program
- Provide an opportunity to practice teaching selected portions of the program
- Discuss practical implementation issues

Program Fidelity

Coming soon.

Program Background

Beginning in the 1980s, a series of evaluation studies have been conducted to test the effectiveness of substance abuse prevention approaches based on the LifeSkills model. These studies have helped to facilitate the development of a prevention approach that is effective with different problem behaviors when implemented by different types of providers, and with different populations.

The focus of the early research was on cigarette smoking and involved predominately White, middle-class populations. More recent research extended this work to other problem behaviors including substance use. In addition, this research has increasingly focused on the utility of this approach when used with inner-city, minority populations. Finally, this research has assessed the long-term durability of the LifeSkills training prevention model, its impact on hypothesized mediating variable, and the importance of high fidelity implementation.

The LST program emphasizes the development of important personal and social skills. Some of the material included in the program relates to the acquisition of general life skills, whereas other material relates in a more direct and specific way to the problem of substance abuse. For example, in addition to general assertiveness skills (i.e., the use of "no" statements, requests, and the assertive expression of rights), students are taught how to use these skills to resist direct peer pressure to smoke, drink, or use marijuana. Students are taught a wide range of personal and social skills in order to improve their general competence and reduce potential social pressures to use one or more psychoactive substances.

The LST program can be divided into five major components: (1) a cognitive component designed to present information concerning the short- and long-term consequences of substance use, current prevalence rates, and social acceptability, as well as the process of becoming dependent on tobacco, alcohol, or marijuana; (2) a decisionmaking component designed to foster the development of critical thinking and responsible decisionmaking; (3) a coping skills training component designed to provide students with techniques for coping with anxiety; (4) a social skills training component, including both general social skills and assertiveness techniques that can be used to effectively resist direct peer pressure to smoke, drink, or use drugs; and (5) a self-improvement project designed to provide students with techniques (i.e., self-evaluation, goal-setting, record-keeping, and self-reinforcement) for changing specific personal skills or

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behaviors.

Program Developer Bio

Gilbert J. Botvin, Ph.D.
Dr. Gilbert J. Botvin, an internationally known expert on drug abuse prevention, developed the LifeSkills program. For the past 20 years, Dr. Botvin has been a full-time faculty member of Weill Medical College at Cornell University, and he currently serves as a professor in both the Department of Public Health and the Department of Psychiatry. Dr. Botvin is also director of Cornell's Institute for Prevention Research. His groundbreaking work in the area of substance abuse prevention has received national and international attention. Most recently (1998), he received the Society of Prevention Research's Presidential Award for prevention research excellence. Dr. Botvin is founding editor of the scientific journal *Prevention Science*, and president of the Society for Prevention Research.

Training Schedule
Coming soon.

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Project ALERT

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E-mail: info@projectalert.best.org
Web site: www.projectalert.best.org

Project ALERT is a drug prevention curriculum for middle-school students (11 to14 years old), which dramatically reduces both the onset and regular use of substances. The 2-year, 14-lesson program focuses on the substances that adolescents are most likely to use: alcohol, tobacco, marijuana, and inhalants. Project Alert use participatory activities and videos to help:

- Motivate adolescents against drug use
- Teach adolescents the skills and strategies needed to resist prodrug pressures
- Establish nondrug-using norms

Guided classroom discussions and small group activities stimulate peer interaction and challenge student beliefs and perceptions, while intensive role-playing activities help students learn and master resistance skills. Homework assignments that also involve parents extend the learning process by facilitating parent–child discussions of drugs and how to resist using them. These lessons are reinforced through videos that model appropriate behavior.

Awards and Recognition

Model Program: Center for Substance Abuse Prevention, 1999
Exemplary Program: U.S. Department of Education, 2001
Exemplary Program: White House Office of National Drug Control Policy
Exemplary Program: National Prevention Network, the National Association of State and Alcohol and Drug Abuse Directors, the Community Anti-Drug Coalitions of America
Endorsed by the National Middle School Association

How It Works

Trained teachers typically deliver Project ALERT in a classroom setting, but some districts have adapted it for use in after-school settings where trained personnel are available.

Implementing Project ALERT involves staff in the following activities:

- Participating in a one-day training workshop
- Teaching 11 core lessons during the first year and three booster lessons the following year
- Promoting parent involvement through home learning opportunities

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To deliver lessons effectively, teachers need to establish an open, supportive classroom environment, facilitate student participation, reinforce good performance, help students acquire the confidence that they really can resist pro-drug pressures, and respond appropriately to student questions about drugs.

Target Population

Project ALERT is highly effective with middle-school adolescents, 11 to 14 years, from widely diverse backgrounds and communities. The program has proved successful with high- and low-risk Caucasian, African American, Latino, Asian American and Native American youth from urban, rural, and suburban communities and a variety of socioeconomic backgrounds. The original program was tested in schools in different geographic areas with different population densities, and among students with a range of racial/ethnic and economic backgrounds.

Protective Factors

Protective Factors To Increase

Individual

- Reasons not to use drugs
- Perceptions that few peers use, most disapprove
- Belief that one can resist prodrug pressures
- Intentions not to use
- Belief that friends respect nonusers
- Ability to identify and counter advertising appeals
- Multiple strategies for resisting drugs
- Ability to identify and resist internal pressures to use

Family

- Communication with parents and other adults

School

- Establishment of norms against drug use
- Cooperative learning
- Respect for others

Peer

- Motivation and skills to help friends avoid drug use
- Responsible behavior modeled by peers

Risk Factors

Risk Factors To Reduce

Individual

- Current use of alcohol, tobacco, or other drugs
- Intention to use in the future
- Belief that drug use is not harmful or has positive effects
- Belief that drug use is normal
- Low self esteem

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- Inadequate resistance skills

Family
- Lack of clear norms against use
- Poor communication

School
- High levels of drug use
- Low norms against use

Peer
- Peer drug use
- Peer approval of drugs

Benefits

Project ALERT helps adolescents:
- Understand the consequences of using drugs
- Develop reasons not to use
- Understand the benefits of being drug-free
- Recognize that most people do not use drugs
- Identify and counter pro-drug pressures
- Resist advertising appeals
- Support others in their decisions not to use
- Learn how to quit
- Communicate with parents
- Recognize alternatives to substance use

Evaluation Design

Project ALERT used a rigorous pre-post design with random assignment of 30 schools to one control and two treatment conditions (i.e., an adult teacher group and an adult teacher plus teen leader group). The participating schools had diverse student bodies. Nine schools had a minority population of 50 percent or more.

Trained data collectors administered student surveys in all schools before and after program lessons. Self-reported drug use was validated by testing saliva samples collected from students and by consistency analyses over time. Logistic regression was used to analyze substance use outcomes as a function of treatment and baseline covariates. Multiple controls helped rule out alternative explanations of treatment effects. All analyses were adjusted for attrition and clustering of students within schools.

Outcomes

Project ALERT was effective in schools with both large and small minority populations from a variety of socioeconomic backgrounds, with youth experimenting with drugs and at risk for becoming regular users, as well as those who had not tried drugs before the program began. It substantially decreased prodrug attitudes and beliefs, including intentions to use drugs, beliefs that drug use is not harmful, and perceptions that many peers use drugs. It also increased beliefs that one can successfully resist both internal and external pressures to use drugs. The program markedly reduced the use of marijuana and cigarettes and the initiation of marijuana

use.

With this program, 15 months after baseline, relative to controls:

- Marijuana initiation rates were 30% lower for ALERT students
- Current marijuana use was 60% lower in adult-led programs
- Current and occasional cigarette use was 20 to 25% lower among baseline experimenters
- Regular and heavy cigarette use was one-third to 55% lower among baseline experimenters
- Antidrug beliefs were significantly enhanced, with many effects persisting into 10th grade. These beliefs included:
    - Intentions not to use within the next 6 months
    - Beliefs that one can successfully resist prodrug pressures
    - Beliefs that drug use is harmful and has negative consequences
    - Beliefs that peers respect nonusers
    - Perceptions that few peers use or approve of using substances

Implementation Essentials

Project ALERT lessons should be taught 1 week apart over the course of 11 weeks for Year 1 and 3 weeks for Year 2.

Teachers need to participate in a 1-day training workshop where they learn the rationale and theory underlying Project ALERT, the skills needed to deliver the lessons, and implementation guidelines for achieving program fidelity. The location and dates of upcoming training workshops are listed on the program's Web site (See Contact Information on page 4).

Teachers leave the training workshop with the following resources:

- A manual with 11 lessons for Year 1 and three booster lessons for Year 2
- Eight interactive student videos
- Twelve full-color classroom posters
- Demonstration videos of key activities and teaching strategies
- An overview video for colleagues and community members
- Project ALERT periodically updates and distributes curriculum videos, posters, and other information to trained teachers free of charge.

Technical Assistance is provided through an online faculty advisor, toll-free telephone support, and newsletters. A fidelity instrument is available to monitor implementation quality.

Program Fidelity

Project ALERT's fidelity instrument is posted on their Web site. Go to Project Alert's Web Site to download their fidelity instrument.

Program Background

In the early 1980s, the RAND Corporation, an internationally recognized nonprofit institution established to improve policy and decision-making through research and analysis, assessed the effectiveness of three major strategies for curtailing adolescent drug use: prevention, law enforcement, and treatment. Based on that study's conclusions, the Conrad N. Hilton Foundation funded RAND to develop and test Project ALERT between 1983 and 1993.

National dissemination of the program, underwritten by the Hilton Foundation, began in 1991. Project ALERT has a presence in all 50 States. More than 18,000 teachers in approximately

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3,500 school districts use Project ALERT in their classrooms. RAND is now developing and testing an enhanced version of Project ALERT that is designed for high schools.

Program Developer Bio

Phyllis Ellickson, Ph.D.
Phyllis Ellickson and colleagues at RAND developed and evaluated Project ALERT. Project ALERT has its own dissemination organization established by the Hilton Foundation to train teachers in effective implementation of the program, provide technical assistance, and periodically update classroom materials. It is subsidized by ongoing funding from the Hilton Foundation.

Training Schedule
The 1-day Project ALERT training usually runs from 8:00 a.m. until 4:00 p.m. with sign-in starting 30 minutes before the workshop begins. The morning is first filled with basics on the background of and research behind Project ALERT, and then role-playing and learning strategies as they are laid out in the curriculum. The afternoon sees continued role-playing but much of that time is spent discussing the curriculum and reactions to it.

At the end of the full day of training, everyone receives a certificate of completion and ongoing support in the form of periodic video and print updates to the curriculum, access to a toll-free technical support line, and a free subscription to The ALERT Educator newsletter published three times a year.

Visit the Project ALERT Web site for a Training Schedule by State and by date.

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Project Towards No Tobacco Use (TNT)

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Web site: www.cdc.gov/nccdphp/dash/rtc/curric7.htm

Training:
Fran Deas
Phone: (626) 457-6634
E-mail: Deas@hsc.usc.edu

Project Toward No Tobacco Use (TNT) of the University of Southern California is a school-based prevention project designed to delay the initiation and reduce the use of tobacco by middle school children.

- Virtually any school or school district can implement Project TNT. It is delivered by trained teachers in classroom settings. Project TNT originally targeted students in seventh grade. Since then, it has been implemented with 10- to 15-year-old white/non-Hispanic, Latino, African American, and Asian American adolescents.
- The theory underlying Project TNT is that young people will be best able to resist using tobacco products if they become aware of misleading social information, develop skills that counteract social pressure to use tobacco, and learn about the physical consequences of tobacco use, such as addiction.
- Project TNT was successful in reducing initiation of cigarettes and smokeless tobacco use, reducing weekly or more frequent cigarette smoking, and eliminating weekly or more frequent smokeless tobacco use

Awards and Recognition

Model Program: Center for Substance Abuse Prevention, 1999
Effective Program: Centers for Disease Control and Prevention
Exemplary Program: Department of Education

How It Works

Project TNT consists of 10 core lessons and 2 booster lessons, each 40 to 50 minutes in length. The 10 core lessons are designed to occur during a 2-week period, although they can be spread over 4 weeks on the condition that all lessons are taught. A 2-lesson booster is taught in a 2-day sequence 1 year after the core lessons. However, boosters can be taught at the rate of 1 lesson per week.

An implementation manual provides step-by-step instructions for completing each of the 10 core lessons and 2 booster lessons together with introductory and background material. Also, there are two videos (one on assertive refusal and the other on combating tobacco use specific social images), a student workbook, and an optional kit that includes posters and other instructional materials.

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At the completion of this program, students will be able to describe the course of tobacco addiction and disease, the consequences of using tobacco, and the prevalence of tobacco use among peers; demonstrate effective communication, refusal, and cognitive coping skills; identify how the media and advertisers influence teens to use tobacco products; identify methods for building their own self-esteem; and describe strategies for advocating no tobacco use.

Target Population

Project TNT has been implemented with 10- to 15-year-old white/non-Hispanic, Latino, African American, and Asian American adolescents.

Protective Factors

Protective Factors to Increase:

Individual

- Accurate knowledge of the course of tobacco addiction and disease, the consequences of using tobacco, and the prevalence of tobacco use among peers
- Effective communication, refusal, and cognitive coping skills
- Awareness of how the media and advertisers influence teens to use tobacco products
- Self-esteem enhancement
- Strategies for advocating no tobacco use (activism)

Family

- Better understanding of tobacco addiction among adults

Peer

- Reinforcement of responsible classroom behavior

School

- Assertion of no tobacco use at school

Community

- Activism (i.e., letter writing to discourage mass media promotion of tobacco use or products)

Risk Factors

Risk Factors to Decrease

Individual

- Poor social skills
- Low self-esteem, susceptibility to negative peer social influence

Community

- Tobacco use myths
- Tobacco use prevalence overestimates
- Tobacco use social images

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Benefits

The TNT program is designed for students to achieve the following objectives:

- Describe the course of tobacco addiction and disease, the consequences of using tobacco, and the prevalence of tobacco use among peers
- Demonstrate effective communication, refusal, and cognitive coping skills
- Identify how the media and advertisers influence teens to use tobacco products
- Identify methods for building their own self-esteem
- Describe strategies for advocating no tobacco use

Evaluation Design

A comprehensive, 10-day, classroom-based, social influences oriented curriculum was delivered to seventh grade students, of whom 60 percent were white non-Hispanic, 27 percent Latino, 7 percent African American, and 6 percent Asian American. Students were taught about tobacco addiction and disease, correction of inflated tobacco use prevalence estimates, social skills, the ways the media portrays tobacco "social images," antitobacco use social advocacy, and how to make a public commitment about tobacco use. Student involvement was maintained through use of five homework assignments, a classroom competition, and a two-lesson booster program provided the next year. Five conditions (four programs and the "usual school health education" control) were contrasted using a randomized experiment involving 6,716 seventh grade students from 48 junior high schools. Four curriculums were developed. Three of these curriculums were designed to counteract the effects of separate (single) program components (normative social influence, informational social influence, and physical consequences), whereas a fourth, comprehensive curriculum, Project TNT, was designed to counteract all three effects. To determine outcomes, 1- and 2-year followups were conducted after the core seventh grade intervention was delivered.

Outcomes

The experimental trial found that relative to control groups, students in Project TNT:

- Reduced initiation of cigarettes by an average of 26 percent (over 2 years of followup).
- Reduced initiation of smokeless tobacco use by approximately 30 percent.
- Reduced weekly or more frequent cigarette smoking by approximately 60 percent.
- Eliminated weekly or more frequent smokeless tobacco use.
- Project TNT was effective for ethnically diverse youth.

View or download a sample post-test student survey in Adobe Acrobat (.pdf) format.

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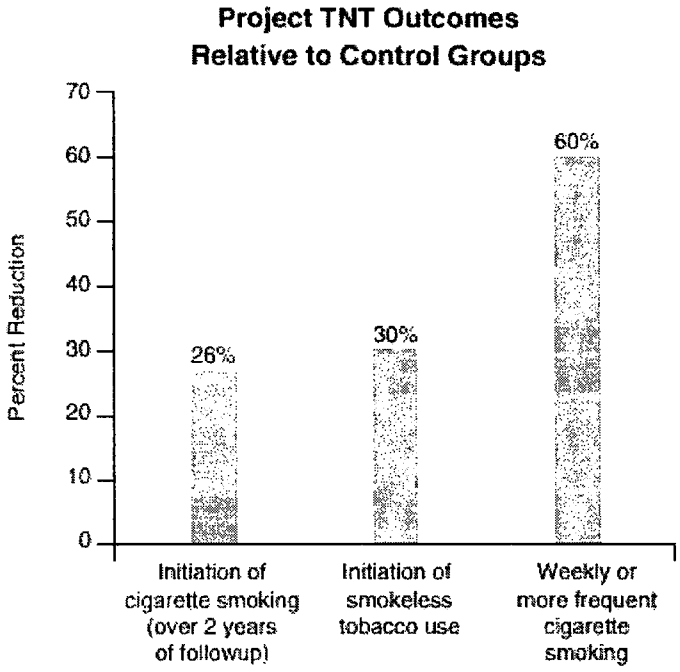

Implementation Essentials

What You Need to Implement the Program

- Dedicated, enthusiastic, trained teachers
- Ten 40- to 50-minute periods for implementation
- Program materials, equipment, and supplies

Staffing and Other Ratios

Project TNT is delivered by classroom teachers to standard size classes.

Implementation Timeline

Project TNT's 10 core lessons are designed to be implemented during a 2-week period, although they can be spread over 4 weeks if all lessons are taught. The two-lesson booster was developed to be taught 1 year after the core lessons in a 2-day sequence. However, the booster can be taught as one lesson per week, perhaps in the subsequent semester.

Teacher Training

Project TNT can provide a 2-day teacher training prior to implementation. This training is highly recommended.

Technical Assistance

Teacher training and research assistance are provided by Project TNT personnel upon request. For teacher training, please call Sande Craig (former project manager of Project TNT) at (626) 457-5887. For research questions, please call Steve Sussman at (323) 442-2594.

To arrange for training, contact:

Fran Deas
Phone: (626) 457-6634
E-mail: Deas@hsc.usc.edu

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Program Materials and Resources

- An implementation manual providing step-by-step instructions for completing each of the 10 core lessons and 2 booster lessons together with introductory and background material
- Two videos (one on assertive refusal and the other on combating tobacco use specific social images)
- A student workbook
- An optional kit that includes posters and other instructional materials
- A 2-day teacher training prior to implementation of the curriculum is recommended. To find out whether your State has developed that capacity, call the tobacco prevention coordinator at your State Department of Education or State Department of Health.

To order the teacher's manual ($45) and student workbooks ($18.95 for set of 5), contact the publisher:

ETR Associates
P.O. Box 1830
Santa Cruz, CA 95061-1830
1(800) 321-4407
Fax: 1(800) 435-8433
Web site: http://www.etr.org

Cost subject to change without notice.

To order other project materials, *Stand Up for Yourself! Peer Pressure and Drugs* video ($79.95) and *Tobacco Use Social Images* video ($40), posttest ($2.50), or project papers ($2.50 each), contact:

Fran Deas
Phone: (626) 457-6634
E-mail: Deas@hsc.usc.edu

Cost subject to change without notice.

To obtain the book that summarizes Project TNT and information on how to develop school-based tobacco use prevention and cessation programs (*Developing School-Based Tobacco Use Prevention and Cessation Programs* by Sussman, Dent, Burton, Stacy, & Flay, 1995), contact:

Sage Publications, Inc.
2455 Teller Road
Thousand Oaks, CA 91320-2218
(805) 499-9774
E-mail: order@sagepub.com

Program Fidelity
Coming soon.

Program Background
The theory underlying Project TNT is that young people will be best able to resist using tobacco products if they (1) are aware of misleading social information that facilitates tobacco use (e.g., advertising, inflating prevalence estimates), (2) have skills that counteract the social pressures to gain peer approval by using tobacco, and (3) appreciate the physical consequences that tobacco

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use may have on their own lives. Project TNT is designed to counteract different causes of tobacco use simultaneously because multiple causes determine the behavior. This comprehensive approach is well suited to a wide variety of youth who may differ in risk factors that influence their tobacco use.

Program Developer Bio

Steve Sussman, Ph.D., FAAHB
Steve Sussman is a professor in the University of Southern California's Departments of Preventive Medicine and Psychology and holds a position at the Institute for Health Promotion and Disease Prevention Research. He has published over 170 articles, chapters, or books in the area of substance abuse prevention and cessation. Recent projects include Project Towards No Tobacco Use (TNT), a tobacco use prevention program. He also helped develop Project EX, which is among the largest and most successful teen tobacco use cessation trials to date.

Training Schedule
Coming soon.

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American Teacher
Oct. 1999--Speakout

Does the D.A.R.E. program work?

No
Donald R. Lynam
There is no evidence to support it

Drug and Alcohol Resistance Education (D.A.R.E.), a popular and widely used anti-drug program in many of our nation's schools, has been the subject of a number of rigorous experimental evaluation studies as well as many not-so-rigorous ones. Scientifically sound studies have failed to find any short- or long-term effects of D.A.R.E. on drug use.

Our recently published 10-year follow-up study is no exception. We followed a cohort of children who were sixth-graders when the study began. Of the 31 schools they attended, 23 were randomly assigned to receive D.A.R.E. in the sixth grade while the other eight received whatever drug education was provided in their classes. Participants were assessed yearly through the 10th grade and recontacted when they were 20 years old. Consistent with other scientifically sound studies, we found that D.A.R.E. had no effect on students' drug use at any time through 10th grade. Our 10-year follow-up failed to find any "sleeper" effects (i.e., effects showing up later that were not present earlier). At age 20, there were no differences between those who received D.A.R.E. and those who did not in their use of cigarettes, alcohol, marijuana or other drugs; expectancies about these drugs; or levels of peer pressure resistance. The only difference was that those who received D.A.R.E. reported slightly lower levels of self-esteem at age 20.

Representatives of D.A.R.E. America have argued that we did not use "a no-treatment" control, that we evaluated an old version of the curriculum and that D.A.R.E. is meant to be administered in elementary, middle and high school. These attacks are without merit.

First, our study was longitudinal and used an appropriate scientific design (i.e., random assignment), unlike the studies sometimes cited in support of D.A.R.E. The "non-D.A.R.E. intervention" was so minimal as to qualify as a no-treatment control. Second, although it is true that our study evaluated the "original" core elementary curriculum, any changes to the curriculum have been more cosmetic than real. The basic elements remain the same (administration by police, to all children regardless of risk, with a focus on increasing peer pressure resistance, and an underlying zero-tolerance message). Third, although it is possible that multiple administrations of D.A.R.E. would be more effective, there are no scientifically strong studies demonstrating that this is the case. Given that the original elementary school curriculum was ineffective (even immediately after administration of it), why should we believe that providing more of it will prove effective?

In the end, D.A.R.E. America has resorted to these false attacks because there are no rigorous scientific studies with which to refute our conclusions. D.A.R.E. has received hundreds of millions of dollars for 16 years in the absence of evidence of its effectiveness. Perhaps it is time we D.A.R.E.d to try something else.

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Yes
Glenn Levant:
D.A.R.E. is helping to stem drug abuse

In the battle against illicit drugs, "we've turned the corner." These were the words voiced this summer by Health and Human Services Secretary Donna Shalala as she and the national drug czar, Gen. Barry McCaffrey, released the results of the annual HHS National Household Survey on Drug Abuse.

The survey, which is one of the very few credible national measures of drug abuse, reports a statistically significant decline of 13 percent in teen drug abuse during 1998. Now it's time to set the record straight. D.A.R.E., the prevention education program that teaches children to avoid drugs, alcohol, tobacco and violence, has played a key role in the overall national strategy that has helped enable America to reach this important milestone.

Community efforts have also played a key role, as has the vital role of individual parents and family members who each day, at home and at work, make this their highest priority. The common denominator in the collective efforts of the team--government, law enforcement, health care providers, religious organizations and families--is education. And although there are many worthwhile prevention programs, none has successfully touched more young people in America than D.A.R.E.

Today, the D.A.R.E. program is taught in more than 80 percent of all U.S. school districts, benefiting 26 million students this year alone. Clearly, D.A.R.E. has played a pivotal role in helping reverse the direction of teen drug use in America.

The D.A.R.E. sequential curriculum is in its ninth generation of improvement and, more importantly, it is the only prevention program that includes elementary, middle and high schools. Thus, students receive vital reinforcement of the principles necessary to provide them the knowledge and skills to avoid not only drugs--but also alcohol, tobacco and violence.

D.A.R.E. is not a government program. It is implemented at the local level at the request of parents, school districts and law enforcement. More than 10,000 communities have D.A.R.E. in place, and each month, scores of communities initiate or expand the D.A.R.E. program.

We realize that D.A.R.E. is not a panacea for the multifaceted epidemic of drug abuse--there is no silver bullet. Nor do we claim that D.A.R.E. is solely responsible for this recent significant and encouraging decline in drug usage by our youth. D.A.R.E. is, however, a vital component of a comprehensive solution that includes caring parents and strong community partnerships.

Glenn Levant is president and founding director of D.A.R.E. America and former deputy chief of the Los Angeles Police Department.

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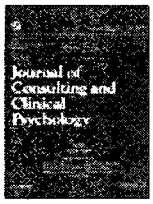

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Project DARE: No Effects at 10-Year Follow-Up

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ABSTRACT

The present study examined the impact of Project DARE (Drug Abuse Resistance Education), a widespread drug-prevention program, 10 years after administration. A total of 1,002 individuals who in 6th grade had either received DARE or a standard drug-education curriculum, were reevaluated at age 20. Few differences were found between the 2 groups in terms of actual drug use, drug attitudes, or self-esteem, and in no case did the DARE group have a more successful outcome than the comparison group. Possible reasons why DARE remains so popular, despite the lack of documented efficacy, are offered.

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The use of illegal substances in childhood and adolescence occurs at an alarming rate. In response to this problem, there has been a widespread proliferation of schoolwide intervention programs designed to curb, if not eliminate, substance use in this population. Project DARE (Drug Abuse Resistance Education) is one of the most widely disseminated of these programs (Clayton, Cattarello, & Johnstone, 1996).

The widespread popularity of DARE is especially noteworthy, given the lack of evidence for its efficacy. Although few long-term studies have been conducted, the preponderance of evidence suggests that DARE has no long-term effect on drug use (Dukes, Ullman, & Stein, 1996; McNeal & Hansen, 1995; Rosenbaum, Flewelling, Bailey, Ringwalt, & Wilkinson, 1994). For example, Clayton et al. (1996) examined the efficacy of DARE among over 2,000 sixth-grade students in a city school system. The students' attitudes toward drugs, as well as actual use, were assessed before and after the intervention and then for the next 4 years through 10th grade. Although the DARE intervention produced a few initial improvements in the students' attitudes toward drug use, these changes did not persist over time. More importantly, there were no effects in actual drug use initially or during the follow-up period. Further, results from shorter term studies are no more encouraging; these studies suggest that the short-term effects of DARE on drug use are, at best, small. In a meta-analysis of eight evaluations of the short-term efficacy of DARE, Ennett, Tobler, Ringwalt, and Flewelling (1994) found that the average effect size produced by DARE on drug use was .06, an effect size that does not differ significantly from zero.

Given the continued popularity of DARE, the limited number of long-term follow-ups, and the possibility of "sleeper effects" (effects showing up years after program participation), it seems important to continue to evaluate the long-term outcomes of DARE. The present study followed up the Clayton et al. (1996) sample through the age of 20. As far as we know, this 10-year follow-up is the longest reported

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on the efficacy of DARE. The original study, although presenting 5-year follow-up data, assessed adolescents during a developmental period when experimentation with drugs is quite prevalent and even considered normative by some authors (Moffitt, 1993; Shedler & Block, 1990). The prevalence of minor drug use during this period may suppress the effects of DARE. However, by the age of 20, experimentation with drugs has reached its peak and begun to decline; it may be during this period that the effects of DARE will become evident. In fact, Dukes, Stein, and Ullman (1997) reported a 6-year follow-up that demonstrated an effect for DARE on the use of harder drugs when participants were in the 12th grade; this effect was not present 3 years earlier.

Method

Participants

The initial sample for this study consisted of sixth graders in the 1987–1988 academic year in a Midwestern metropolitan area of 230,000. An overwhelming majority of the sample came from urban or suburban areas. With regard to socioeconomic status (SES), the area is considered one of the more prosperous counties in a state known for its pockets of extreme poverty. Although actual SES measures were not collected, given the size and inclusiveness of the sample, the sample can be assumed to represent all economic strata. Of the initial sample, 51% were male and 75% were White.

Data were collected before and after the administration of DARE. Follow-up questionnaire data were collected from the students over a 5-year period from 6th through 10th grade. Of the original participants, completed questionnaires were obtained on at least three occasions (once in 6th grade, once in 7th or 8th grade, and once in 9th or 10th grade) for 1,429 students. This became the sample targeted for the present young adult follow-up study. Completed mailed surveys were received from 1,002 participants between the ages of 19 and 21.

The final sample of 1,002 consisted of 431 (43%) men and 571 (57%) women. The average age of the participants was 20.1 *(SD* = 0.78 *)*. The racial composition of the sample was as follows: 748 (75.1%) were White, 204 (20.4%) were African American, and 44 (0.4%) were of other race or ethnicity. Seventy-six percent of the final sample had received DARE, which corresponds almost exactly to the 75% of sixth graders who were originally exposed to DARE.

We conducted attrition analyses to determine whether the 1,002 participants differed from those 427 individuals who were eligible for the mailed survey study but from whom no survey was obtained. A dummy variable representing present–missing status was simultaneously regressed using a pairwise correlation matrix onto 15

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variables from the original assessment: sex; ethnicity; age; DARE status; peer-pressure resistance; self-esteem, and use of, and positive and negative expectancies toward, cigarettes, alcohol, and marijuana. Missing status accounted for a small but significant proportion of the variance in the linear combination of the 15 study measures ($R^2 = .06$), $F(15, 1339) = 6.08$, $p < .001$, but only 3 variables were independently linked to missing status. Participants who were missing completed surveys tended to be older males who reported using cigarettes in the sixth grade. In general, attrition seemed to have little effect on the results that are reported here.

Procedures

Those individuals who could be located were sent a letter and a consent form requesting their participation in a follow-up to their earlier participation in the DARE evaluation. Those individuals who returned the signed consent form were mailed a questionnaire that took approximately 30 to 45 min to complete. Of the available sample, 5 had died, 176 refused to participate, 83 could not be located, and 163 were contacted but did not return the survey. For their time and effort, participants were paid $15 to $50.

Measures

Similar to the earlier data collection, participants were asked questions about their use of alcohol, tobacco, marijuana, and other illegal drugs. For each drug category, participants were asked to report how often they had used the substance in their lifetime, during the past year, and during the past month. In addition, participants were asked a variety of questions concerning their expectancies about drug use. For each drug, respondents reported how likely they believed using that drug would lead to five negative consequences (e.g., "get in trouble with the law" and "do poorly at school or work") as well as how likely they believed using that drug would lead to eight positive consequences (e.g., "feel good" and "get away from problems"). Negative and positive expectancy scores were formed for each drug at each age. Two potential mediators of the DARE intervention, peer-pressure resistance and self-esteem, were also assessed. Participants responded to nine items designed to assess the ability to resist negative peer pressure (e.g., "If one of your best friends is skipping class or calling in sick to work, would you skip too?"). Finally, participants responded to the 10-item Rosenberg Self-Esteem Scale (Rosenberg, 1965). All scale scores had acceptable reliabilities (alphas ranged from .73 to .93, with an average of .84).

Initial DARE Intervention

A complete description of the experimental and comparison interventions is contained in the Clayton et al. (1996) study.

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Twenty-three elementary schools were randomly assigned to receive the DARE intervention, whereas the remaining 8 schools received a standard drug-education curriculum. The DARE intervention was delivered by police officers in 1-hr sessions over 17 weeks. The focus of the DARE curriculum is on teaching students the skills needed to recognize and resist social pressures to use drugs. Additionally, the curriculum focuses on providing information about drugs, teaching decision-making skills, building self-esteem, and choosing healthy alternatives to drug use. The control condition was not a strict no-treatment condition but instead consisted of whatever the health teachers decided to cover concerning drug education in their classes. The drug education received by students in the control condition cannot be described in detail because of the considerable latitude on the part of teachers and schools in what was taught. Nonetheless, in many instances, emphasis was placed on the identification and harmful effects of drugs, peer pressure was frequently discussed, and videos using scare tactics were often shown. These drug education units lasted approximately 30 to 45 min over a period of 2 to 4 weeks.

Results and Discussion

Because the school, and not the individual, was the unit of randomization in the present study, we used hierarchical linear modeling, with its ability to model the effect of organizational context on individual outcomes. For each of the substances (cigarettes, alcohol, and marijuana), we constructed three hierarchical linear models (HLMs) that examined amount of use, positive expectancies, and negative expectancies. We conducted additional analyses on peer-pressure resistance, self-esteem, and the variety of past-year illicit drug use. An HLM was used to model the effect of DARE on the school mean of each dependent variable (drug use and expectancies) while controlling for pre-DARE factors. This allowed for the comparison of how each school mean varied with the effect of DARE. We conducted preliminary analyses in which the effect of DARE was also modeled on the relationship between pre-DARE baseline and the substantive outcomes. Significant effects would suggest that DARE affected the relation between pre- and post-DARE outcomes. These effects were not significant and were thus fixed across schools. Respondents' sixth-grade reports of lifetime use served as baseline measures, whereas age-20 reports of past-month use of cigarettes, alcohol, and marijuana served as outcome measures. [1] The results of the full HLMs are presented in Table 1.

Cigarettes

Pre-DARE levels of use and negative expectancies about cigarette use were significantly related to their counterparts 10 years later. There were no relations between DARE status and cigarette use and expectancies, suggesting that DARE had no effect on either student

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behavior or expectancies.

Alcohol

Pre-DARE levels of lifetime alcohol use and positive and negative expectancies about alcohol use were significantly related to their counterparts 10 years later. DARE status was unrelated to alcohol use or either kind of alcohol expectancy at age 20.

Marijuana

Pre-DARE levels of past-month marijuana use and negative expectancies about use were significantly related to their counterparts 10 years later. Similar to the findings for cigarettes, respondents' sixth-grade positive expectancies about marijuana use were not significantly related to marijuana expectancies at age 20. DARE status was unrelated to marijuana use or either kind of marijuana expectancy at age 20.

Illicit Drug Use

Finally, the number of illicit drugs (except marijuana) used in the past year was examined. Because no measures for these items were obtained during the initial baseline measurement, we estimated a means-as-outcomes HLM using no Level 1 predictors and only DARE status as a predictor at Level 2. The results show that DARE had no statistically significant effect on the variety of illicit drugs used.

Peer-Pressure Resistance

The results for peer-pressure resistance were similar to previous results. Pre-DARE levels of peer-pressure resistance were significantly related to peer-pressure resistance levels 10 years later, whereas DARE status was unrelated to peer-pressure resistance levels.

Self-Esteem

Finally, pre-DARE levels of self-esteem were significantly related to self-esteem levels at age 20. Surprisingly, DARE status in the sixth grade was negatively related to self-esteem at age 20, indicating that individuals who were exposed to DARE in the sixth grade had lower levels of self-esteem 10 years later. This result was clearly unexpected and cannot be accounted for theoretically; as such, it would seem best to regard this as a chance finding that is unlikely to be replicated.

Our results are consistent in documenting the absence of beneficial effects associated with the DARE program. This was true whether the outcome consisted of actual drug use or merely attitudes toward drug use. In addition, we examined processes that are the focus of

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intervention and purportedly mediate the impact of DARE (e.g., self-esteem and peer resistance), and these also failed to differentiate DARE participants from nonparticipants. Thus, consistent with the earlier Clayton et al. (1996) study, there appear to be no reliable short-term, long-term, early adolescent, or young adult positive outcomes associated with receiving the DARE intervention.

Although one can never prove the null hypothesis, the present study appears to overcome some troublesome threats to internal validity (i.e., unreliable measures and low power). Specifically, the outcome measures collected exhibited good internal consistencies at each age and significant stability over the 10-year follow-up period. For all but two measures (positive expectancies for cigarettes and marijuana), measurements taken in sixth grade, before the administration of DARE, were significantly related to measurements taken 10 years later, with coefficients ranging from small ($\beta = 0.09$ for positive expectancies about alcohol) to moderate ($\beta = 0.24$ for cigarette use). Second, it is extremely unlikely that we failed to find effects for DARE that actually existed because of a lack of power. Thus, it appears that one can be fairly confident that DARE created no lasting changes in the outcomes examined here.

Advocates of DARE may argue against our findings. First, they may argue that we have evaluated an out-of-date version of the program and that a newer version would have fared better. Admittedly, we evaluated the original DARE curriculum, which was created 3 years before the beginning of this study. This is an unavoidable difficulty in any long-term follow-up study; the important question becomes, How much change has there been? To the best of our knowledge, the goals (i.e., "to keep kids off drugs") and foci of DARE (e.g., resisting peer pressure) have remained the same across time as has the method of delivery (e.g., police officers). We believe that any changes in DARE have been more cosmetic than substantive, but this is difficult to evaluate until DARE America shares the current content of the curriculum with the broader prevention community.

One could also argue that the officers responsible for delivering DARE in the present study failed to execute the program as intended. This alternative seems unlikely. DARE officers receive a structured, 80-hr training course that covers a number of topics, including specific knowledge about drug use and consequences of drug use, as well as teaching techniques and classroom-management skills. Considerable emphasis is given to practice teaching and to following the lesson plans. Although we did not collect systematic data on treatment fidelity in the present study, a process evaluation by Clayton, Cattarello, Day, and Walden (1991) attested to the fidelity to the curriculum and to the quality of teaching by the DARE officers.

Finally, advocates of DARE might correctly point out that the present study did not compare DARE with a no-intervention condition but

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rather with a control condition in which health teachers did their usual drug-education programs. Thus, technically, we cannot say that DARE was not efficacious but instead that it was no more efficacious than whatever the teachers had been doing previously. Although this is a valid point, it is unreasonable to argue that a more expensive and longer running treatment (DARE) should be preferred over a less expensive and less time-consuming one (health education) in the absence of differential effectiveness (Kazdin & Wilson, 1978).

This report adds to the accumulating literature on DARE's lack of efficacy in preventing or reducing substance use. This lack of efficacy has been noted by other investigators in other samples (e.g., Dukes et al., 1996; Ennett et al., 1994; Wysong, Aniskiewicz, & Wright, 1994). Yet DARE continues to be offered in a majority of the nation's public schools at great cost to the public (Clayton et al., 1996). This raises the obvious question, why does DARE continue to be valued by parents and school personnel (Donnermeyer & Wurschmidt, 1997) despite its lack of demonstrated efficacy? There appear to be at least two possible answers to this question. First, teaching children to refrain from drug use is a widely accepted approach with which few individuals would argue. Thus, similar to other such interventions, such as the "good touch/bad touch" programs to prevent sexual abuse (Reppucci & Haugaard, 1989), these "feel-good" programs are ones that everyone can support, and critical examination of their effectiveness may not be perceived as necessary.

A second possible explanation for the popularity of programs such as DARE is that they *appear* to work. Parents and supporters of DARE may be engaging in an odd kind of normative comparison (Kendall & Grove, 1988), comparing children who go through DARE with children who do not. The adults rightly perceive that most children who go through DARE do not engage in problematic drug use. Unfortunately, these individuals may not realize that the vast majority of children, even without any intervention, do not engage in problematic drug use. In fact, even given the somewhat alarming rates of marijuana experimentation in high school (e.g., 40%; Johnston, O'Malley, & Bachman, 1996), the *majority* of students do not engage in any drug use. That is, adults may believe that drug use among adolescents is much more frequent than it actually is. When the children who go through DARE are compared with this "normative" group of drug-using teens, DARE appears effective.

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Table 1
Hierarchical Linear Models Examining the Influence of Project DARE on Age-20 Levels of Drug Use, Drug Expectancies, Peer-Pressure Resistance, and Self-Esteem

Variable	Fixed effect [a]
Frequency of past-month cigarette use	
Intercept (γ_0)	–.076
Level 1: Pre-DARE lifetime cigarette use (β_1)	.240***
Level 2: DARE status (γ_1)	.101
Negative expectancies toward cigarettes	
Intercept (γ_0)	.108
Level 1: Pre-DARE expectancies (β_1)	.145***
Level 2: DARE status (γ_1)	–.152
Positive expectancies toward cigarettes	
Intercept (γ_0)	–.071
Level 1: Pre-DARE expectancies (β_1)	.009
Level 2: DARE status (γ_1)	.053
Frequency of past-month alcohol use	
Intercept (γ_0)	–.034
Level 1: Pre-DARE lifetime alcohol use (β_1)	.115**
Level 2: DARE status (γ_1)	–.018
Negative expectancies toward alcohol	
Intercept (γ_0)	.075
Level 1: Pre-DARE expectancies (β_1)	.105**
Level 2: DARE status (γ_1)	–.034

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Positive expectancies toward alcohol	
Intercept (γ_0)	−.052
Level 1: Pre-DARE expectancies (β_1)	.085*
Level 2: DARE status (γ_1)	.048
Frequency of past-month marijuana use	
Intercept (γ_0)	.033
Level 1: Pre-DARE lifetime marijuana use (β_1)	.098**
Level 2: DARE status (γ_1)	−.044
Negative expectancies toward marijuana	
Intercept (γ_0)	−.013
Level 1: Pre-DARE expectancies (β_1)	.123***
Level 2: DARE status (γ_1)	.039
Positive expectancies toward marijuana	
Intercept (γ_0)	−.021
Level 1: Pre-DARE expectancies (β_1)	.045
Level 2: DARE status (γ_1)	.011
Variety of illegal drugs used in past year [b]	
Intercept (γ_0)	−.081
Level 2: DARE status (γ_1)	.080
Peer-pressure resistance	
Intercept (γ_0)	.058
Level 1: Pre-DARE peer-pressure resistance (β_1)	.118**
Level 2: DARE status (γ_1)	−.139
Self-esteem	
Intercept (γ_0)	.133
Level 1: Pre-DARE self-esteem (β_1)	.129**
Level 2: DARE status (γ_1)	−.181*

Note. DARE status is coded 0 = control, 1 = DARE intervention.

[a] All beta coefficients presented are group-mean-centered, standardized effect sizes. [b] There were no baseline measures for this model; thus, a means-as-outcomes model was estimated.

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* $p < .05$; ** $p < .01$; *** $p < .001$.

Footnote

[1] Results were unchanged when prevalence of use or heavy use, rather than frequency of use, was used as the outcome variable.

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What Does the National Research Say About D.A.R.E.?

In general, the results of the studies support positive short-term effects of D.A.R.E. First, D.A.R.E. is presented as a primary prevention program. This means that the program is directed at the general population, i.e., all fifth graders, rather than individuals at high risk (secondary prevention) or those who are already using drugs (tertiary prevention). As such the methods are more general and meant to be only part of a long-term, comprehensive strategy. D.A.R.E. is not designed to be a stand-alone program or to provide 5th graders with all skills and information they will need to make healthy decisions later in life. Ideally, D.A.R.E. is a part of an on-going, multi-dimensional approach to prevention that spans the elementary, middle and high school years.

Most of the long-term evaluation studies appear to have looked at a one-to one relationship between participation in 17 weeks of D.A.R.E. and individual drug use behaviors several years later. It is probably unrealistic to expect one "dose" of any primary prevention program to prevent an outcome as complex as drug use. Prevention is a multiple step, multiple strategy effort based on the assumptions that protecting children from risk and promoting healthy behaviors go hand in hand, and that each prevention effort should build on past efforts and support future efforts.

The short-term positive outcomes of the D.A.R.E. program are well supported in the literature, and are indicators of success for the program. The impact of D.A.R.E. on long-term, drug use prevention is not well supported. However, communities can strengthen the impact of the program by ensuring that D.A.R.E. is part of a multiple grade level, integrated, and comprehensive prevention strategy, not a stand-alone, one-time program.

The second issue brought out by a literature review is the role of the D.A.R.E. police officers-as instructors, role models and community members. The studies that looked closely at the role of the officers, found them to be well trained, dedicated, and an important part of the success of the program. In particular, the more involved the officers were with the children, the teachers and the schools in general, the better the outcomes for the students.

The third issue is the role of the teacher. The national D.A.R.E. program encourages teachers to be active participants, and to integrate the D.A.R.E. lessons into other aspects of the educational process. Although only addressed briefly in literature it was mentioned as an important component of successful outcomes.

What are the Benefits of D.A.R.E.?

Beyond the short-term effects for students, D.A.R.E. appears to have other benefits that parallel the degree to which the program is implemented. For example, D.A.R.E. provides important opportunities for involvement with law enforcement, the community, teachers, and parents. However, it is up to the school districts and local law enforcement to use these opportunities effectively. D.A.R.E.

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offers three grade appropriate curriculums, a parent component, strong support for effective teaching and other elements that can make it a well integrated, comprehensive prevention strategy. It is up to the school districts and local law enforcement to take advantage of these optional components. Thus, the program's benefits appear to be commensurate with the degree to which it is implemented.

Perhaps one of the most important benefits of D.A.R.E. for communities is its scope. When it is administered to all 5th graders, the program provides a common frame of reference for an entire cohort. The students have a common experience and a common base of knowledge from which they make individual and group decisions. It seems to be a reliable way to reach all 5th graders with clear and consistent drug and violence prevention messages.

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Initial Results Positive for New D.A.R.E. Program

Washington, D.C., December 27: A new study shows that students who were taught the new D.A.R.E. (Drug Abuse Resistance Education) curriculum showed improved communications skills and beliefs about the prevalence of substance use -- two key indicators of whether they will use drugs.

The feasibility study of the new D.A.R.E. 7th grade curriculum was conducted in 11 middle schools in Ohio with 460 students in fall 2000. The study analyzed the short-term effects of the curriculum on student mastery of refusal skills, normative beliefs about peer substance use, and the physical, social and psychological effects of substance use on adolescents. Results were consistent across all participants in the study, regardless of their gender, sex, which school they attended, or which officer taught their class. The Institute for Health and Social Policy at the University of Akron conducted the feasibility study with funding from the Robert Wood Johnson Foundation.

Key improvements among the students in the program included:

- A significant increase in refusal skills.
- A significant decrease in their perception of peer drug use.
- A significant decrease in the percentage of students who believed that substance use by students their own age was common and acceptable.

The seventh grade program and a ninth grade program will be evaluated through a rigorous national study. This is the first national study to blend the latest in prevention science with D.A.R.E., the largest prevention delivery network in existence. D.A.R.E. operates in 80% of all school districts around the country and reaches 36 million young people each year. The new curricula incorporates the most up-to-date evidence and research-based strategies for substance abuse prevention programming.

The evaluations study is currently being conducted in middle and high schools in and around six U.S. cities, including Detroit, Houston, Los Angeles, Newark, New Orleans, and St. Louis. If the national test shows positive, long-term results for the curriculum, it will be expanded to D.A.R.E. programs nationwide.

The Institute for Health and Social Policy at the University of Akron was established in 1999 for the study of the delivery of effective health and social services. The goal of the Institute is to improve the quality of services delivered to communities and individuals nationwide in order to decrease negative health and social consequences.

The Robert Wood Johnson Foundation, based in Princeton, NJ, is the nation's largest philanthropy devoted exclusively to health and health care. It concentrates its grantmaking in three goal areas: to assure that all Americans have access to basic health care at reasonable cost; to improve care and support for people with chronic health conditions; and to reduce the personal, social, and economic harm caused by substance abuse -- tobacco, alcohol, and illicit drugs.

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Re-Examining the Role of Recreation and Parks in After-School Programs

Peter A. Witt[1]

Note: The following paper appeared as part of two different articles in Parks and Recreation[2].

There is growing consensus that after-school programs are needed to serve children of all ages. In a nationwide poll of 800 registered voters, conducted in 2000 by Charles Stewart Mott and JC Pennys, 82% indicated they thought after-school programs were a necessity, and 69% felt there were not enough after-school programs or slots in existing programs. In addition, 92% of voters strongly agreed, or agreed, that there is a need for some type of organized activity or place where children can go after school every day that provides opportunities to learn. Most importantly, 62% indicated that paying for after-school programs should be all taxpayers' responsibility and were willing to pay $100 more per year in state taxes to provide after-school programs.

America's police chiefs also see the need to increase the provision of after-school programs. Based on data compiled by the National Incident-Based Reporting System, they recognize that the prime time for violent crime is from 3:00-6:00 p.m. (Sickmund, Snyder, & Poe-Yamagata, 1997). During these hours, kids are most likely to become victims of violent crime, be killed by household or other accidents, get hooked on cigarettes, and experiment with drugs. There is also evidence that teens are mostly likely to engage in sexual intercourse and girls become pregnant during these hours; this is also a key time period for kids of all ages to get hooked on video games that too often provide training for violent behavior (Newman, Fox, Flynn, & Christeson, 2000). Ninety-one percent (91%) of police chiefs agreed that: "If America does not make greater investments in after-school and educational child care programs to help children and youth now, we will pay far more later in crime, welfare, and other costs." They favored prevention strategies for reducing juvenile crime, with 57% identifying after-school and summer youth programs as the number one means (Mastrofski & Keeter,1999).

Why After-School Programs

Defining exactly what constitutes an after-school program is problematic since programs are created by a variety of organizations, have a variety of goals, and serve a range of children. However, in general, the rationale for programs can be grouped into three categories: (a) the growing need for child care; (b) concerns for using

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[2]Witt, P.A. (July, 2001). Re-examining the role of recreation and parks in after-school programs. Parks and Recreation. 36(7): 20-28. & Witt, P.A. (September, 2001). Insuring after-school programs meet their intended goals. Parks and Recreation. 36(9): 32-52.

after-school hours for improving educational achievement; and (c) the linkage of after-school program development to school reform agendas.

Safety Issues and the Need for Child Care. In their landmark 1992 study, the Carnegie Council on Adolescent Development note that the transition to adolescence has become more difficult because of the increasing number and accessibility of dangerous alternatives for time use when young people are not in school coupled with the uneven availability of safe and healthy activities with enough appeal to attract and hold the attention of young people.

Shifts in family and community life also increase the need for after-school programs for younger children as well (Halpern, Deich, & Cohen, 2000; Newman, et. al., 2000). Welfare reform has led to the need for safe places for children to be while parents are working (Reno & Riley, 2000). Most parents feel less stressed knowing that their children are in a protected environment. Leaving younger children at home to be watched by older children is not a satisfactory arrangement and denies older children time to "just be kids."

Currently over 28 million school-age children have parents who work outside the home, but only about six million children K-8 participate in after-school programs (Bureau of Labor Statistics, 1997; U.S. Department of Education National Center for Education Statistics, 1999). Thus, there is a need to increase after-school program slots for children who potentially are in a self-care situation after school. Self-care has been associated with several negative outcomes. Self-care children have been found to be more lonely (Quay, 1992), anxious, headstrong, and likely to have peer conflicts (Vandell & Ramanan, 1991), less likely to complete their homework (Long & Long, 1989), and have poorer emotional well-being (Vandell, Posner, Shumow & Kang, 1995) than children who either have adult care after school or attend structured, supervised after-school programs. Self-care children tend to be more involved with peers, have more contact with deviant peers, and boys have poorer parent-adolescent relations (Galambos & Maggs, 1991). Steinberg (1986) found that children who "hang out" after school were most susceptible to peer pressure, followed by those children who went to a friend's house, followed by those children who went home.

Increasing Opportunities for Educational Attainment. A second impetus for increasing after-school program opportunities is interest in boosting educational attainment. There is a widespread believe that to raise achievement test scores, time must be increased during which children are involved in educational activities beyond the school day (Newman, et. al., 2000). The lack of scholastic support and/or role models in the homes of many inner-city youth provides further impetus for the development of after-school programs. It is hoped that over time after- school programs will decrease the number of school dropouts and increase school attendance, grades, and standardized test scores.

In many after-school programs, recreation is thought of as the "hook" that attracts children to become involved. However, simply involving children in fun and games is not viewed as sufficient for increasing educational achievement. Thus, in many settings, particularly when school personnel are involved, efforts are being

made to "enrich" recreation activities by using them as tools for purposive learning. In addition, students are either provided with tutoring or given the opportunity to complete homework by themselves or with assistance from program personnel. Tutoring is also common when children's parents have a low level of educational attainment themselves and/or low English language skills, both of which might deny children the opportunity to receive help at home with assigned homework.

In all cases, the provision of caring adult leaders and enrichment activities planned as purposive interventions are critical program elements. Along with appropriate controls against deviant behavior and the absence of negative peer influences, among other program elements, have been cited as contributing to positive learning experiences for children (Jessor, 1992). After-school programs can make an important contribution by offering program elements that help mediate between risks that are inherent in the child's environment and the consequences that may occur as a result of subsequent behaviors (Witt, Baker, & Scott, 1996; Witt & Crompton, 1997).

However, Alexander (2000) has expressed concern that over emphasis on student learning and achievement may potentially undermine or diminish achievement of other critical after-school program goals. He recommends the viability of project-based activities that combine the best of play and academics as an alternative to a strict adherence to after-school becoming simply more school.

Halpern (1999) further warns that after-school programs need to avoid just being a place where improvement in something tangible is sought. He notes that "it will be difficult for school-age programs to create the psychological space children need if there is too much pressure to serve instrumental purposes" (p. 93). Many community organizations operate on the principal that children need a break from formal learning and the chance to just be kids. However, focusing solely on safety and recreation may not meet the requirements of parents and school personnel for increased attention to educational achievement.

Reforming Schools. Changing the ways schools operate has also been a central interest for some after-school program advocates. These reformers have viewed the fight for obtaining funding for after-school programs as a medium through which parents and other community leaders can be organized, and subsequently focus on more fundamental school reform issues. Thus, the Federal 21st Century Community School Learning Centers initiative was designed not only to provide quality after-school programs for children, but as a first step to accomplishing school reform objectives.

Stakeholder Issues

Stakeholders differ on which after-school objectives to emphasize. Larner, Sippiorli, & Behrman (1999) note that children want competence, relationships, autonomy; parents want their children to be supervised and in an enriched environment; and the public at large wants prevention of risk behaviors and improved academic performance. Teachers may be interested in programs mainly as a means for extending the school day and thus improving test scores.

Thus, a central issue in after-school program design is the balance between stakeholders' views (Baker & Witt, 2000).

For example, Larner, et al. (1999) noted that "because the new resources are public dollars, they are linked to policy goals that are salient to the voters and elected officials. But, after-school programs will succeed only if they also appeal to parents and children" (p. 17). Given the potential for tension between competing agendas, there is a need for partnerships between service providers and other stakeholders that can give full voice to the differing views of what an after-school program should be.

Increasing Park and Recreation's Role in Offering After-School Programs

While park and recreation departments are filling some of the need for after-school programs, in many cases, park and recreation departments are left out of the after-school program discussion or relegated to a fun and games, service provision, role. There are three reasons for the lack of inclusion.

First, the national education lobby has successfully argued for the need to extend the school day and closely tie after-school programs to increasing school attendance, academic achievement, and standardized test scores. They have convinced lawmakers that after-school programs can help achieve these objectives.

Second, most park and recreation departments have been unable to position themselves as major players when educational goals are put forth as the dominant rationale for creating after-school programs. In some cases, where recreation departments have had a chance to become involved in after-school program efforts, they have steadfastly insisted that they are not in the education and or tutoring business, and that kids should not have to spend after-school time involved in educational/enrichment activities. In other cases, recreation departments have not wanted to run programs at school-based sites, fearing that they would not get sufficient credit for being involved or that the program would be dominated by school personnel.

Third, voluntary non-profit sector organizations, like the Boys and Girls Clubs, YMCAs, YWCAs, or PALs, have better positioned themselves as providers of after-school programs. Being niche organizations, with more limited target markets than park and recreation departments, these organizations are better equipped to command community attention and support for the specialized services they provide. They often concentrate energy and resources on "at- risk" target groups and many of these organizations have undertaken more cooperative efforts with schools.

Park and recreation departments used to be one of the major providers of after-school services. However, shrinking budgets and the subsequent need to offer programs on a fee for service basis led to the demise of many of these efforts. Other youth serving organizations have long recognized the value of recreation activities as settings through which instrumental goals can be accomplished. In particular, the parks and recreation field lags behind in efforts to incorporate program elements that maximize educational impacts. Recently park and recreation agencies have again begun to appreciate the necessity of being involved in the amelioration of social problems in their communities. Park and Recreation departments need to recognize societal expectations and the forces driving the need for after-school programs if they are to

become a significant player in the after-school program movement.

Documentation of outcomes associated with after-school program participation is increasing. However, to date, no comprehensive meta-analysis of outcome studies has been undertaken, but several catalogs of outcomes have emerged over the last several years (e.g., Fashola, 1998; Reno & Riley, 1998, 2000). While the results of these outcome studies can be criticized from a number of perspectives, awareness of what is and is not working can assist program providers greatly in designing quality after-school programs.

Just what are the problems with these studies? Fashola (1998) undertook a review of outcome studies and concluded that, methodologically, research is at a rudimentary stage. A number of studies fail to meet minimal research design standards. For example, selection bias is a problem leading to failure to account for why some children attend programs and others do not. Random assignment of children who wish to be in a program is difficult from both a practical and political point of view, thus many studies do not meet the required rigor to establish cause and effect between program and outcomes. In addition, many studies rely on retrospective post-test-only designs (notably, however, this practice is widespread in large-scale national evaluations of many social programs).

Many organizations do not have the expertise or financial resources to undertake evaluation beyond post-test only surveys designed to measure program quality. At the same time, few studies have attempted to look at changes beyond a one-year perspective.

In addition, the surveys used have often not been subjected to procedures to determine their reliability or validity. Reports by children, parents or teachers may be biased because of fear that, if no impact is found, programs might be canceled. Given the necessity for after-school childcare in many participating families, parents may overstate impacts simply to preserve the program. Additionally, in a number of cases, outcome data is based on the opinions of experts instead of formal evaluations. Awareness of these flaws in existing outcome studies is an important step towards improving the quality of evaluation down the road.

One factor that makes evaluations more difficult should be considered. Many after-school programs are not designed to meet their stated objectives. For example, a program intended to achieve changes in academic performance might not contain opportunities for homework completion or tutoring or provide appropriate enrichment activities (Witt & Baker, 1997).

A Growing Body of Evidence Supporting After-School Programs

Despite the difficulties outlined above, there seems to be a growing body of evidence that after-school programs can make a difference (see Figure 1 for a list of potential programmatic outcomes). For example, decreases in juvenile crime have been associated with participation in a number of different after-school programs (Fox & Newman, 1998; Mclennan Youth Collaboration, 1997; Schinke, Orlandi, & Cole, 1992). Children in after-school programs (versus non-participants) have reported feeling safer than during the after-school program hours (Brooks, et al., 1995), and the Baltimore Police Department

reported a 44 percent drop in children becoming crime victims after starting an after-school program in a high crime area (Baltimore Police Department Division of Planning and Research, 1998).

Better grades and high academic achievement also appear to be associated with after-school programs that contain academic or enrichment components. For example, in 30 of the 40 schools that had children participating in the Chicago Lighthouse Program, children showed achievement gains in reading scores, with 39 schools showing gains in mathematics scores (Chicago Public Schools Office of Schools and Regions, 1998); students participating in the LA's Best after-school program were reported to have made academic gains beyond students not participating in the program (Brooks & Mojica, 1995); and Baker and Witt (1996) reported that the more students were involved in an after-school program, the more academic performance improved. Thirty-month follow-up evaluation of children participating in the Boys & Girls Club's Project Learn indicated an increase in grade average, school attendance, and study skills compared to children not participating in the program (Schinke, Cole, & Poulin, 1998).

A number of studies have also reported increases in school attendance and reduced drop-out rates. McLennan Youth Collaborations (1997) found that 57 percent of students participating in the after-school program improved their school attendance, while Cardenas et al. (1991) reported that absences for students participating as tutors in a cross-age tutoring program was one percent compared to a comparison group's 12 percent rate.

Several studies have reported that students participating in after-school programs have shown fewer behavior problems (Gregory, 1996; Steinberg, Riley, & Todd, 1993), handle conflicts better (Carlisi, 1996; Gregory, 1996), and show improved social skills (Steinberg, Riley, & Todd, 1993; Terao, 1997).

Increases in parental involvement in the lives of their children who participate in an after-school program have also been documented. This outcome is mainly accomplished through either requiring, or strongly encouraging, parents to volunteer in their child's after-school program (Carnegie Council, 1992) or teaching parents how to help their children with homework (Chicago Public Schools, 1998).

After-school program attendance has also been associated with helping children increase their aspirations for the future, including their intention to go to and complete high school. For example, one survey reported that students in after-school activities are more likely to indicate that school is preparing them for college and that they plan to attend university (Peter D. Hart, Research Associates, 1999), while other studies have reported higher graduation rates as a result of after-school participation (e.g., Hahn, Leavitt, T., & Aaron, P., 1994). Finally, at least one study has documented the cost savings ($72,692 over three years) because students participating in an after-school program avoided being retained in grade or being placed in special education (Gregory, 1996).

The Characteristics of Good After-School Programs

While there is widespread belief that promising models for after-school programs

exist, it is not yet clear which models or elements of models are the most effective (Fashola, 1998). While there is a growing literature on the program elements necessary to produce desired outcomes, efforts are still in their early stages.

Several reports have attempted to identify the critical program elements necessary to bring about desired results. For example, reports by the California Department of Education (1996) and Roman (1998) have indicated that successful programs should offer age-appropriate learning activities, a low student-staff ratio, qualified staff, linkages with the regular school program and with community organizations, safety, a wide range of both structured and unstructured activities, program evaluation, and parent involvement.

Gambone and Arbreton (1997) have identified seven program practices and organizational features hypothesized to be associated with high levels of youth development experiences: providing informal and formal opportunities for leadership; enabling to receive social support from adults; creating a sense of belonging; providing challenging and interesting activities; providing opportunities for input and decision making; providing opportunities for community service; and creating a safe environment.

In addition, Olsen and Scharf (2000) have noted the importance of after-school programs being accessible and available to all by honoring ethnic and cultural diversity needs of participants. They contend that: "Where a young person lives determines what level and quality of services they receive" (p. 1) and that few programs serve an enrollment representative of the ethnic, cultural, and probably socio-economic make-up of the areas served.

Overall, two program elements have emerged as particularly significant: (1) program involvement that has sufficient intensity and duration to bring about desired results, and (2) the availability of caring, committed and qualified adults who can develop in depth, meaningful relationships with participants (Witt & Crompton, 1999).

Intensity and Duration (or "Dosage")

The duration, amount, and intensity of the program, or "dosage," participants receive appears to be directly related to outcomes. For example, Huang, et al. (2000) in a study of the LA's Best program, followed students in a program from 1993-94 school year to 1997-98, and looked at differences in outcomes as a result of high involvement with the program (more than 75% of days present); medium involvement (26 to 74%) of days; and low involvement (25% or less) of days. Their findings suggest that for students who participated over at least 4 years, higher participation was related to positive achievement on standardized math, reading and language arts tests (after controlling for gender, ethnicity, income, and language status). Their results suggest that higher levels of participation led to better subsequent school attendance, which in turn is related to higher academic achievement as measured by standardized test scores.

Feister, White, Reisner, and Castle (1999) report that the impact of an after-school program on cognitive and emotional development was greatest for those students with high rates of average attendance. Baker and Witt (1996) came to similar conclusions regarding academic progress variables.

Thus, besides providing in-depth programming, programs should not be offered for a short period of time and then dropped. This limits programmatic impact and usefulness. Failing to create on-going opportunities for involvement ignores that the need for a safe and secure environment is on-going, five days per week, throughout the school year, during after-school hours; and for many children, during school holidays, teacher days, and summer vacation periods as well.

The Necessity of Caring Adults

The importance of committed and caring adults is emphasized in almost every article written about after-school programs. Kahne, et al. (1999) found that students in a variety of different programs reported preferring the affective context of after-school program to that experienced during the school day. This may be due to school-day programs placing more emphasis on order, discipline, and control, while after-school programs are generally less formal and structured.

However, Kahne, et al. (1999) also suggest that after-school programs may offer more support for youth development by providing frequent contact with other participants and a developmental, rather than a recreational, focus. In addition, programs that provide meaningful support do more than provide safe and pleasant contexts: they are staffed by individuals who reach out to and build trusting relationships with youth, monitor their development, and intervene when necessary.

Good leaders will be able to encourage youth to be physically and mentally engaged, and should be able to actively motivate and appropriately reward acceptable behavior. To accomplish these ends, they should know and understand how to utilize basic principles of child development.

Necessity of Adequate Resources

Programs should have enough resources to do a good job. In many cases providers have not fully understood the costs involved in such an endeavor (Halpern, Deich, & Cohen, 2000). Agreeing to run a program on a shoe-string may create the impression that no additional funding is needed. In addition, it may lead to a self-fulfilling prophecy: that the service is either not worth supporting or will be of low quality. Permanent sources of funding are preferable to an endless string of grants and other one-time sources. Political officials (city councils, park and recreation commissions, school boards, etc.) should be lobbied to make a commitment to fund programs as a basic service. Funding should also be at a level that insures an appropriate leader to child ratio (1:15 for children 9 years and older and 1:10 for younger children). In addition, funding should be sufficient to pay salaries at rates that attract and keep committed staff. Low pay and lack of benefits can lead to staff turnover and low quality of employees (Halpern, Spielberger, & Robb, 2000). This, in turn, can impact participants' trust and program outcomes.

After-school programs appear to have great potential to impact the lives of participants. While evaluation information is still sparse, data is increasing that properly designed and implemented programs can achieve a multitude of important goals beyond just keeping kids in a safe and secure environment until their parents come to pick them up.

Research into Action

Documentation of outcomes associated with after-school program participation is increasing. However, to date no comprehensive meta-analysis of outcome studies has been undertaken, but recentely several catalogs of outcomes have emerged. A body of knowledge is emerging indicating that after-school programs can bring about changes in a number of areas, including: crime reduction (by creating positive spaces for children to be during the after-school hours); an increase in positive behaviors (including improved social skills, ability to handle conflicts, decreasing use of drugs and alcohol); and increased self-confidence. Positive relationships have also been found between after-school program involvement and increased school performance, including interest in going to school and school achievement. Academic-related outcomes are dependent on creating a program that has strong homework completion and enrichment components. Finally, after-school programs can have impacts on strengthening schools, families and communities, and increasing parents involvement in their children's education.

Quality evaluation and documentation is critical both to help justify programs to funding sources and to facilitate program improvement. While existing evaluation studies have a variety of methodological problems, there is clear evidence that properly planned programs (e.g. those that include the appropriate amount of involvement of children with the program and quality leadership) have the potential to make critical differences in the lives of children, their family, and their community.

If programs are not able to generate their own evaluation data, there is body of knowledge that can be used to justify program development. However, communities should make evaluation an important part of their programmatic efforts to both add to existing knowledge about program outcomes and to create local information that will strongly resonate with local funding sources and stakeholders. Other suggestions can be made based on this research:

- Program designers should also be aware of the relationship between program design and program outcomes. Purposively planned programs have the best chance of achieving results. Program goals should be carefully selected in concert with the schools and parents. Subsequently, programs can be designed with specific components to meet the pre-determined goals. The figure included in this research update provides a comprehensive list of typical program outcomes.

- Evaluations should be designed to specifically address goals and program components. Consider partnering with a university program for assistance with evaluation during the program planning stage.

- Programs should be both in-depth and long-term to meet children's need for a safe, secure environment. This means planning for five days a week, plus vacations and holidays when some parents will have to work. Programs should strive to find permanent funding; inform stakeholders about your plans and form partnerships to build lasting financial support.

- Committed, caring adults are one key to program success. The importance of hiring, training and retaining quality staff is key. The children will benefit most when staff are committed and able to reach out and build trusting relationships with youth. Parent involvement can be encouraged through volunteer opportunities.

- Providers need to consider the ethic and cultural diversity of the areas they serve and proactively ensure that programs serve all members of the community.

Figure 1: Outcomes Associated with After-School Programs[3]

I. Safe and Secure Environment

Crime reduction

* decreased juvenile crime
* decreased violent victimization
* decreased vandalism at schools

Prevention of negative behaviors and increase of positive behavior

* preventing negative influences that lead to risky behaviors such as drug, alcohol and tobacco use
* decreased television watching
* fewer behavioral problems generally
* increased ability to handle conflicts
* improved social skills
* improved self confidence

II. School Performance

* increased grades and higher academic achievement
* increased interest in and ability to read
* improved school attendance and reduced dropout rate
* turning in more and better quality homework
* increased time on task
* reduced retention in grade and placement in special education
* improved school behavior
* monetary savings to school districts
* development of new skills and interests
* higher aspirations for the future, including intention to complete high school and to go to college.

III. School Reform

* strengthening schools, families and communities
* greater family and community involvement in children's learning and schools
* increased parental involvement in schools
* development of community schools

[3]Reno, J. & Riley, R.W. (2000). Working for children and families: Safe and smart: making the after-school hours work for kids. Washington, D.C.: U.S. Department of Education. Http://www.ed.gov/pubs/SafeandSmart/http://www.ed.gov/pubs/parents/SafeSmart/

Federal Agencies Directly Involved with Substance Abuse Prevention

Listed below are the different federal agencies involved with substance abuse prevention and a brief description of their respective roles.

Centers for Disease Control and Prevention (CDC)
Atlanta, Georgia
The CDC is the federal agency charged with protecting the nation's public health. Through its Planned Approach to Community Health (PATCH) program, CDC works with State and local health departments to organize local intervention programs on issues such as tobacco and alcohol use. The CDC provides written material about prevention and technical assistance.

Substance Abuse and Mental Health Services Administration (SAMHSA)
Rockville, MD
SAMSHA administers alcohol and other drug and mental health service-related programs. The agency's focus is on prevention, intervention, and treatment services and its primary role is to coordinate the delivery of these services to health professionals and the general public. SAMSHA consists of three agencies: the Center for Substance Abuse Prevention (CSAP), the Center for Substance Abuse Treatment (CSAT), and the Center for Mental Health Services (CMHS).

SAMSHA's Center for Substance Abuse Prevention (CSAP)
Rockville, MD
CSAP was established in 1986 to lead the federal government's efforts on the prevention and intervention of alcohol, tobacco, and other drug problems. CSAP administers the Community Partnership and High-Risk Youth grant programs, as well as other prevention programs. CSAP also manages the National Clearinghouse for Alcohol and Drug Information (NCADI), the federal government's central repository of information related to alcohol, tobacco, and drugs.

Department of Education (DOed)
Washington, DC
The DOEd administers the largest block of federal funds allocated for the prevention of alcohol and other drug problems through the Division of Drug-Free Schools and Communities. DOEd provides Safe and Drug-Free Schools formula funding through State education agencies and governors' offices; oversees DOEd's five Regional Centers for Drug Free Schools and Communities that supply technical assistance to schools and communities; and administers grants for State and local education agencies in five discretionary grant programs for school personnel training and school-based community programs in alcohol and other drug prevention education.

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Department of Housing and Urban Development (HUD)
Washington, DC
HUD operates the HUD Drug Information and Strategy Clearinghouse that deals with alcohol and other drug problems in public housing projects. Until this year, HUD also administered the Drug Elimination Grant program that funded a range of activities aimed at eliminating alcohol abuse and illicit drug use in public housing project. This grant program will not be funded after the end of the current (federal government) fiscal year.

Department of Justice
Office of Justice Programs
Washington DC
DOJ operates the National Criminal Justice Reference Service that provides comprehensive information on criminal justice issues, and the Drug and Crime Data Center and Clearinghouse, which specializes in the collection of data on drugs and crime. DOJ also awards formula grants to States and to specific crime prevention programs.

The Office of Juvenile Justice and Delinquency Prevention (OJJDP) provides resources to assist states and local jurisdictions improve their juvenile justice systems. Program priorities include prevention and control of illegal drug use by juveniles, and the prevention and control of serious juvenile crimes.

Office of National Drug Control Policy (ONDCP)
Executive Office of the President
Washington, DC
The White House Office of National Drug Control Policy (ONDCP) is part of the Executive Office of the President. ONDCP's purpose is to establish policies, priorities, and objectives for the nation's drug control program, the goals of which are to reduce illicit drug use, manufacturing, and trafficking, drug-related crime and violence, and drug-related health consequences. To achieve these goals, the Director of ONDCP is charged with producing the National Drug Control Strategy. The Strategy directs the Nation's anti-drug efforts and establishes a program, a budget, and guidelines for cooperation among Federal, State, and local entities.

National Institute on Alcohol Abuse and Alcoholism/NIH
Rockville, MD
NIAAA is a research organization that focuses on alcohol-related problems. NIAAA supports scientific information dissemination and public education activities to inform the public o the risk and consequences associated with alcohol abuse and alcohol dependence.

National Institute on Drug Abuse/NIH
Rockville, MD
NIDA is the lead federal agency for drug abuse research. NIDA disseminates its research findings to the public through the media, community education programs, NIDA's Drug Abuse Hotline, and publications.

The challenge facing the County and its communities in the coming years is to calculate how to keep the spotlight on drug and alcohol prevention efforts and to maintain, and even expand, these high-priority endeavors despite the limited resources.

IV. RECOMMENDATIONS FOR CONTINUING PREVENTION EFFORTS

The CIT reaffirms the basic conviction behind the original action plan set out in 1989: that we as a community must seek to change attitudes and behaviors in regard to alcohol and other drugs, that we must cease to tolerate substance abuse by adults and use of alcohol and other drugs by those under 21, and that we must seek to reduce the demand for alcohol and other drugs. Prevention is crucial to reducing this demand.

Guiding Principles

Substance abuse prevention requires a long-term commitment, with visible leadership from the highest levels of the County.

Special attention must be paid to multi-cultural and low-income populations in all prevention and treatment efforts.

Alcohol and other drug abuse occurs throughout our society -- within all groups and in all geographic areas of the County.

RECOMMENDATION 1: To maintain strong organizational support for prevention efforts within the County government.

A. Urge the County Executive to affirm a strong leadership role in alcohol and other drug abuse prevention. The CIT hopes that this report will give the County Executive the opportunity to commit his administration to the effort and put his own stamp on prevention in Montgomery County. This commitment must be expressed frequently and in a variety of ways. He should:

- Continue funding for prevention.
- Make public statements to the community about the importance of prevention.
- Direct his special assistant and individual department heads to play a leadership role in prevention efforts.
- Meet with his department heads to discuss this report and charge them to attend in person all meetings of the Coordinating Council on Substance Abuse.

B. Continue the work of the Coordinating Council with the attendance of all department heads and confirm its role as the key coordinating governmental entity within the County dealing with substance abuse.

C. Encourage the County Executive's special assistant to play a visible role in prevention. This person can provide leadership to the Coordinating Council and establish strong ties between the County Executive and the Alcohol and Other Drug Abuse Advisory Council.

D. Seek coordination and provide leadership regionally for enforcement of underage alcohol sales laws and consideration of new laws, taxes, and policies that provide a disincentive for the purchase and use of alcohol among youth and adults. More specifically, the CIT urges consideration of the following:

- Enact a law requiring proof of age for all alcohol purchasers assumed to be under the age of 25 years.
- Use the County's unique alcohol sales monopoly to limit the number of alcohol retail outlets in the County. The ratio for alcohol retail outlets to County per-capita population should be limited to the same ratio as existed in 1988.
- Consider the addition of an excise tax on beer sold in Montgomery County to ensure a significant difference in the price of a six pack of beer and a six pack of soft drinks to further discourage purchase and use by youth.
- Require that the alcohol content of wine coolers and similar sweetened alcoholic drinks be clearly marked at the point of sale.
- Discontinue selling "house brands" of alcohol and other price-discounting marketing strategies that encourage additional alcohol use and abuse.
- Ban the use of "toy" dogs and/or other animals as marketing tools for alcohol and tobacco in County retail outlets since they appeal to the youth populations under the legal age for purchase.

E. Facilitate the merger of the Alcoholism Advisory Council and the Drug Abuse Advisory Council into the Alcohol and Other Drug Abuse Advisory Council and confirm its role as the key citizen group advising the County Executive on issues related to substance abuse.

F. Sustain the high level of cooperation and coordination among agencies on issues related to substance abuse prevention, treatment, and enforcement.

G. Maintain the prevention staff within the Department of Family Resources, the County's coordinating agency for human services, because of the department's effective presence within both the public and private sectors.

H. Accelerate the implementation of the County's new personnel policy and procedures as well as its training of supervisors.

I. Support neighborhood empowerment projects through strong interagency collaboration with communities.

J. Request that the County Executive charge the Alcohol and Other Drug Abuse Advisory Council to monitor the implementation of the recommendations made in this report in order to ensure citizen input and oversight.

RECOMMENDATION 2: To continue to focus prevention efforts on the same target groups: families with school-age children and communities with a high incidence of drug-related activities.

A. Educate and train parents -- in identifying the risk factors for the development of alcohol and other drug problems, in parenting skills, in the nature of alcohol and other drug abuse, in networking skills, and in stress management. Reach parents through sports leagues, the workplace, educational programs, and faith organizations. Especially seek to reach multi-cultural and low-income parents.

B. Continue neighborhood empowerment activities and expand to new areas of the County. Build a greater sense of community both within and between neighborhoods, through a wide variety of means.

C. Encourage the faith community to play a larger role in prevention. Reach faith organizations through outreach and training, through involvement in neighborhood empowerment activities, through working with leaders in individual denominations as well as through interfaith coalitions. Explore the possibility of inviting the Church Association for Community Service to provide some expertise to planning and coordinating prevention efforts.

D. Empower youth through such efforts as:

- Inclusion in boards, committees, and councils
- Sponsoring Youth Speak Out programs
- Expanding activities that engage their energies and interests such as arts, sports, and community service projects
- Training in skills development (coping and refusal skills, stress management)
- Training in job skills and job-seeking skills
- Continued sponsorship of the Youth Advisory Committee, SHOP, and SADD

E. Urge SADD to decrease its emphasis on "responsible use" and firmly espouse a "*no* use" policy on alcohol and other drugs for youth.

F. Promote collaborative efforts in the business community through training, networking, and consultation; encourage BAD to expand its outreach and training activities to more employers.

G. Expand peer counseling programs, using a variety of formats, to include groups of youth as well as associations of professionals and volunteers.

H. Provide prevention services to the elderly through training, outreach, and networking.

I. Expand prevention efforts within multi-cultural and low-income populations. Specifically:

- The County Executive should direct the Office of Minority and Multi-Cultural Affairs to take the lead in these efforts.
- Prevention efforts with these populations should permeate every County department.
- The Coordinating Council should assure that this recommendation is pursued; all departments should report each six months to the Coordinating Council on progress made in this area.

J. Pursue a regional leadership role in exploring issues related to the sale of alcohol to minors throughout the metropolitan area.

K. Encourage MCPS prevention staff to study state and federal curriculum requirements (especially for grades 7-12) and compare them with the MCPS curriculum for the prevention of tobacco, alcohol, and other drugs; report on this to the Coordinating Council, County Executive, and Alcohol and Other Drug Use Advisory Council by September 30, 1991.

L. Re-evaluate the County's commitment to DARE and consider more cost-effective methods of teaching resistance skills in the schools.

M. Provide funding for library materials on substance abuse and READ-ON van services to reach low-income communities.

N. Continue support for prevention and treatment services within the criminal justice system to serve both offenders and members of their families.

RECOMMENDATION 3: To maintain public awareness of alcohol and other drug abuse issues and efforts.

A. Encourage the County's Public Information Office to participate as an active partner with other County efforts in prevention and education activities, as this office is a primary link to the news media.

- This office should be represented on the Prevention Education committee of the Coordinating Council.
- The office is encouraged to do monthly promotions of prevention information to the media; information that can be provided by various agencies, such as the Prevention Center, Health Department, MCPS, DAVMHS, or DFR.

B. Establish a half-time media position in the Prevention Center to work closely with the County's Public Information Office and to take full advantage of the abundant resources available in this geographic area through the federal government.

C. Direct the Prevention Center to provide monthly articles or information packets to the Public Information Office for dissemination to the media.

D. Educate and train community-based groups on alcohol and other drug abuse issues as well as strategies for preventing and treating inappropriate use.

E. Direct the Prevention Center to develop a working relationship with the newspapers in public and private high schools to promote prevention messages.

RECOMMENDATION 4: To continue supporting strong roles for enforcement and treatment agencies.

Enforcement:

A. Encourage the shift to community policing to bring the police force closer to County neighborhoods, especially in high-risk areas.

B. Create partnerships with communities through involvement in neighborhood empowerment efforts as well as community policing.

Treatment:

Because a national crisis in health insurance is affecting the County, it is important to maintain adequate treatment resources for the un-insured and the under-insured.

A. Pay special attention to the issue of treating the dually diagnosed, particularly within the criminal justice system; identify gaps in current services and develop ways to address the needs of this special population.

B. Evaluate various treatment modalities and programs to ensure that maximum use is made of limited resources and that delivery of appropriate services be continued.

C. Establish and maintain family-oriented treatment programs, especially ones that help addicted women remain with their children.

RECOMMENDATION 5: To expand evaluation of prevention programs.

Budget limitations require efficient use of funds. One of the best investments is a program that has proven to be truly effective -- this can only be determined through incisive evaluation.

A. Conduct a follow-up household survey as soon as possible to detect changes in public awareness and drug-related activity since the spring of 1989.

B. Develop an appropriate evaluation design for the state-funded mini-grant program which will assess the effectiveness of this program to date and include recommendations for its continuation.

C. Expand evaluation activities in the prevention arena and develop evaluation skills of County and private agency staff.

D. Urge the Coordinating Council on Substance Abuse to review evaluation findings on a regular basis to be sure that the lessons learned in evaluation are put to use.

RECOMMENDATION 6: To continue to pursue alternative sources of funding for prevention efforts.

A. Provide training to agencies and community groups in grantsmanship and fundraising as a way of expanding resources within the County; provide workshops and disseminate written information about grant funding.

B. Maintain current levels of grant funding for County agency prevention efforts.

C. Provide support and encouragement to the Grant Research Acquisition and Backup Committee to continue their collaborative efforts in seeking new sources of outside funding, assisting in the grant writing process, and implementing grants that are funded.

As a way of implementing all of the above recommendations, the CIT proposes that the Department of Family Resources develop each one with more specific action steps in a report to the Substance Abuse Coordinating Council and the Alcohol and Other Drug Abuse Advisory Council by January 1, 1992.

Montgomery County Government

September 30, 1993

Charles L. Short, Secretary
Health and Human Services
401 Fleet Street
Rockville, Maryland 20850

Dear Chuck:

We are pleased to forward to you a proposed Prevention Policy for the Montgomery County Government. Its focus, as requested, is on tobacco, alcohol and other drugs and on children, youth and families. It is important to understand that this policy does not address other age or population groups or broader human service prevention issues.

We believe you will find this to be a very comprehensive statement. While some of the language may seem rather broad (as might be expected for such a public policy) we worked hard to reach a level of specificity that hopefully will make this document a very meaningful one to both the government and the community. You will find in both the purpose statement and the conclusion the hope of our work team that this policy will be used as a serious guide to decision making and resource allocation by appointed and elected county officials. It is also our hope that it will be adopted in whole or part by the wide variety of community-based organizations that are also involved in prevention efforts.

This document will take on meaning only when it is formally endorsed by the County Executive and the County Council. That is the course we recommend to you. Prior to it being forwarded, however, we believe you should subject it to the scrutiny and input of a broad base of both staff and citizen advisors.

While our team has worked hard and produced what we feel is a very good document, we would encourage you to seek out the thoughts of such groups as the Commission for Children and Youth, the Community Partnership, the Alcohol and Drug Abuse Advisory Council, the Substance Abuse Policy Leadership Team and others you may see fit.

The County Council, as you know, has just received public comment regarding their draft Health and Human Services Policy. We are happy to note that the policy language we are recommending to you seems to be well in concert with that being considered by the

Council. It is more specific and direct, but clearly in unison in several key areas including calling on the private sector to be the primary service provider. We believe you should advise the Council soon of this work so they might consider how it will ultimately relate to the broader Health and Human Service Policy.

Our work team spent a brief amount of time in discussion of whether the current government structure is the best suited to implement and be responsive to the policy we are recommending. We recommend consideration of two actions. First is to create a Prevention Team that would operate much along the lines of the other policy teams that you have created within the Secretariat. It would be charged, among other things, with monitoring the consistency of the action of the government with the tenets and intentions of the proposed prevention policy. But we believe it should go well beyond the focus of our work group and extend into the broader prevention arena of other related human service problems and needs. The task that you have charged us with is done now. But a group such as ours, reconstituted to represent interests beyond substance abuse, may serve well as a Prevention Team.

A second step would be to somehow recognize by title change, mission statement or some other demonstrative action, the important prevention work that is done directly or under contract by all human service departments. If prevention is important to us we must let it be known both inside and outside of government. We must also work to make prevention more of a routine and expected part of every human service job.

We appreciate the confidence you have placed in our team by appointing us to this task. You should be aware that there was considerable discussion and debate about virtually every sentence of the document. Two full meetings alone were spent on arriving at what we considered to be the best definition of prevention for the Montgomery County community. The product we place before you is one that we have reached consensus on. The diversity of our personal and professional backgrounds made reaching consensus on every word a formidable challenge. Our shared conviction of the importance of this work, however, made this challenge an easy one to overcome. We would be happy to meet with you if you would like to discuss any particular aspects of the proposed policy.

Sincerely,

(N-2)

Officer Mary Carlin
Maryland National Park Police

Dr. Lillian Durham, Asst. Dir.
Resident Services Division
Housing Opportunities Commission

Harriett Guttenberg, Exec. Dir.
Mental Health Assoc. of Mont. Cty.

Beverly Hassell, Director
The Prevention Center

Joan D. Liversidge
Substance Abuse Coordinator
Division on Children and Youth

Scott McMillin, Director
Addiction Treatment Unit
Suburban Hospital

Robert Myers
Division of Adult Addiction Services
Dept. of Addiction, Victim,
and Mental Health Services

Laurence F. Pignone, Exec. Dir.
United Way of Montgomery County

Joan Planell
Child Welfare Division
Department of Social Services

Fr. Jake Powderly, Sub. Abuse Coord.
Archdiocese of Washington

Ellen Pucciarelli
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Department of Health

Lorraine A. Rogstad, Director
Child & Adolescent Services
Community Psychiatric Clinic, Inc.

Martha Rosacker, Prevention Spec.
Department of Family Resources

Rita Rumbaugh, Sub. Abuse Prev. Spec.
Montgomery County Public Schools

Carol Giannini Small, Drug Prog. Coord.
Council of Governments

Charlie Steinbraker, Committee Chair
Exec. Assistant to the Director
Department of Recreation

Officer Vincent E. Thompson, Jr.
Department of Police

Douglas Tipperman, Staff Director
Mont. County Community Partnership

Michael Ward, Director
YMCA Bethesda Youth Services

POLICY OF THE MONTGOMERY COUNTY GOVERNMENT ON THE PREVENTION OF ALCOHOL, TOBACCO, AND OTHER DRUG ABUSE

INTRODUCTION AND BACKGROUND

According to national research, the abuse of alcohol, tobacco, and other drugs is the nation's leading public health problem. A 1993 report from the Institute for Health Policy Studies indicates there are more illnesses, deaths, and disabilities from substance abuse than any other preventable condition. Of the nearly two million deaths in the U.S. each year, one in four (more than half a million) are directly related to alcohol, tobacco, and drug use (National Center for Health Statistics, 1992). Substance abuse reduces human capital and places a considerable economic burden--estimated at $200 billion--on our country (Rice et al, 1990). This cost includes expenses associated with health care, crime, extra law enforcement, automobile accidents, and loss of productivity. And while substance abuse affects all segments of our society, it disproportionately affects disadvantaged groups and the future of our children.

As local data make clear, Montgomery County is also experiencing widespread alcohol and other drug abuse, as well as its costly consequences. According to the 1992 Maryland Adolescent Drug Survey, nearly one-third of the 12th graders in Montgomery County reported smoking cigarettes in the last month, and 15 percent said they had used marijuana in the same period. Among 8th graders, recent use of crack cocaine rose from 1 percent in 1988-89 to 4.5 percent in 1992. However, alcohol is the drug most commonly used, with 8.5 percent of 6th graders, 20.5 percent of 8th graders, 40.7 percent of 10th graders, and 49.1 percent of 12th graders reporting recent use. In addition, one in every twenty-five 8th graders, one in every six 10th graders, and almost one in three 12th graders reported consuming five or more drinks on at least one recent occasion.

Montgomery County physicians responding to a 1990 survey reported that smoking and the abuse of alcohol and other drugs are the top health-related problems facing Montgomery County children and youth. The most recent cost estimate put the economic costs from just four areas—health care, sick days, loss of productivity, and theft—at nearly $300 million in Montgomery County in 1989 alone.

The abuse of alcohol and other drugs has clear and direct links to other expensive and often life-threatening problems. These include child abuse and neglect , adolescent pregnancy, school truancy and dropping out, AIDS and HIV infection, property crimes, and violence. Perhaps most alarming is the relationship between the use of alcohol and other drugs and family and street violence.Violence has been reported as the number one concern of the American public, and its reduction clearly must be related to the prevention of alcohol and other drug use. More than half of those arrested in the U.S. for major crimes such as homicide, rape, assault, and robbery were using illicit drugs around the time of their arrest and half of the people incarcerated in state prisons for committing violent crimes report that they were under the influence of alcohol or drugs at the time of their offense (National Institute of Justice, 1993).

Nevertheless, concern has also been expressed in a number of forums that the current efforts and strategies to reduce alcohol and other drug abuse are not effective. The National Council on Alcoholism and Drug Dependence notes that interdiction and law enforcement activities have received over 70 percent of our resources in what they refer to as a "failed War on Drugs." It calls for a new strategy to "fight drug-related crime by making prevention and treatment equal partners with interdiction and law enforcement" and "addressing the economic and social factors that contribute to drug addiction and alcohol problems."

Therefore, effectively addressing violence and the other problems linked to alcohol and other drug abuse will require sustained efforts and investments in prevention. This investment will bring several kinds of positive returns to the community. Each dollar spent on prevention will improve the lives of families and communities while saving many future dollars, which otherwise will continue to be needed to cope with the costly consequences of alcohol, tobacco, and other drug abuse.

PURPOSE OF THE POLICY

The purpose of this policy is to provide leadership and guidance to county staff and agencies and a clear message to the entire community about the county government's commitment to prevention. Because numerous studies indicate that most problems begin at early ages, this policy focuses primarily on children, youth, and families.

The policy has four specific purposes:

- To recognize prevention as a critically important force, along with treatment and enforcement, in the effort to reduce and eliminate alcohol, tobacco, and other drug abuse.
- To emphasize that prevention is less expensive and more cost-effective than treatment and enforcement.
- To provide clear direction and expectations to county government agencies, together with motivation and incentives for the involvement of citizens, neighborhoods, businesses, and other community organizations, all of which are essential to a successful prevention effort.
- To reach all segments of the county's diverse population, including all language and cultural groups.

POLICY GOALS

The prevention policy is intended to achieve three broad goals:

- To produce a sustained commitment to support for prevention activities, thereby reducing long-term government expenditures associated with the costly consequences of alcohol, tobacco, and other drug abuse.

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- To improve the productivity of the workforce in the public and private sectors, thereby increasing government efficiency and the county's economic health.

- To reduce the tragic suffering of individuals and families affected by alcohol, tobacco, and other drug abuse and its many associated problems, thereby improving the quality of life throughout the county.

THE PREVENTION POLICY

DEFINITION OF PREVENTION

Montgomery County defines prevention as a multifaceted, proactive process which empowers individuals and systems to meet the challenges of life events and transitions. It does this by creating and reinforcing conditions that promote healthy behaviors and lifestyles. Prevention related specifically to alcohol, tobacco, and other drug abuse is defined as a set of procedures, programs and services designed to reduce the incidence of substance abuse and related problems of individuals, families, and communities.

POLICY STATEMENT

The Montgomery County Government will support policies, programs, and activities and make resource allocation decisions that:

- preserve and enhance the protective and resiliency factors known to reduce the potential use and abuse of alcohol, tobacco, and other drugs.
- reduce or eliminate risk factors known to lead to these problems.

The following section lists these protective factors and risk factors, based on national research.

PROTECTIVE AND RESILIENCY FACTORS

- **Community Protective/Resiliency Factors**: norms and public policies that support non-use among youth; access to crucial resources such as housing, employment, health care, child care, job training, education, and recreation; supportive networks and social bonds; supportive faith community; youth involvement in community service.

- **School Protective/Resiliency Factors**: high expectations; encouragement of goal setting and social development; provision of leadership and decision-making opportunities; fostering of active involvement of students in alcohol and drug free activities; education on alcohol, tobacco, and other drug prevention; parent involvement; mentoring relationships.

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- **Family Protective/Resiliency Factors**: prenatal care; close bonding between child and caregiver; encouragement of continuing parent education; effective management of stress; time together as a family; parenting styles that encourage high warmth and low destructive criticism; limits instead of permissiveness; encouragement and nurturing; clear and consistent expectations; encouragement of supportive relationships with caring adults beyond the immediate family; parental modeling of appropriate behavior.

- **Peer Protective/Resiliency Factors**: involvement in alcohol and drug free activities; respect and work with authority figures; bonding to conventional groups; appreciation for the unique cultural heritage and talents of others.

- **Individual Protective/Resiliency Factors**: social competence; problem solving skills; a sense of identity; the ability to act independently; a sense of purpose and future; knowledge of the effects of alcohol, tobacco, and other drugs.

RISK FACTORS

- **Community Risk Factors**: economic and social deprivation; low neighborhood attachment and disorganization; transition and mobility; community laws and norms favorable to drug abuse or drug availability.

- **School Risk Factors**: early anti-social behaviors, academic failure, low commitment to school.

- **Family Risk Factors**: family history of alcoholism, parental drug use, parental positive or permissive attitudes toward alcohol or other drug use.

- **Individual Risk Factors**: alienation, antisocial behaviors early in adolescence, friends who use alcohol and drugs, favorable attitudes toward alcohol and drugs, predisposition to addictive behaviors, early school failure, poor self-esteem, early first use of drugs.

PREVENTION AS A COMPREHENSIVE APPROACH

The Montgomery County Government recognizes that effective prevention requires a broad set of programs, activities, and practices. In this effort, traditional activities that support resiliency factors are just as important as activities targeted to those at risk. The preventive value of treatment must also be recognized. It is imperative that the prevention and treatment communities work collaboratively with each other and in cooperation with law enforcement.

Listed alphabetically below are some crucial prevention activities, grouped into four basic categories. To be effective, an overall community prevention effort must include all these types of activities.

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Building Protective and Resiliency Factors: Some Examples

- **Public Awareness Activities:** media campaigns, printed materials distribution, public forums, sermons and other information in the faith community, speakers' bureaus, and television and radio news and other programs.
- **Education for Individuals and Families:** employment and financial counseling, job training, parent and family life education, parent support groups, school-based education programs, training for human service providers, youth skill development.
- **Positive youth and peer development:** after-school recreation and extracurricular activities, community service and volunteer opportunities, scouting and faith-based youth groups, summer youth programs such as camps and playgrounds, youth sports leagues.

Reducing Risk Factors: Some Examples

Alternative schools, intervention groups for children and youth, latchkey children's programs, neighborhood empowerment programs, sobriety checkpoints, workplace programs: policies and employee assistance programs, youth and family skill development.

THE ROLE OF THE COUNTY GOVERNMENT

The Montgomery County Government will serve as a facilitator and supporter of prevention services. It will be a primary provider only if the services cannot otherwise be provided directly by the private sector or through private-public partnerships. The County Government's role is also to work toward continuous improvement in the effectiveness of prevention activities.

The County will carry out these roles in the following ways:

- **Facilitate, assist, and support prevention.**
  - Simplify the process of developing public/private partnerships.
  - Work collaboratively with community-initiated and community-based prevention activities and groups.
  - Give consideration to the importance of prevention when establishing or approving policies related to the use of publicly owned space.
  - Examine zoning and land use processes to eliminate barriers and promote the provision of neighborhood-based prevention programs.
  - Encourage the inclusion, in master plans and development plans, of amenities that support neighborhood-based prevention programs.
  - Support broad-based education and awareness efforts
  - Support public and private programs that directly or indirectly promote protective and resiliency factors.
  - Support education programs, particularly programs for children, which identify signs, stages, and the process leading to addiction.
  - Support experientially-based educational efforts, including those in which recovering persons provide effective leadership.

◦**Maintain a balance among prevention, treatment, and enforcement.**

- ◦Monitor funding levels and percentages allocated to prevention, treatment, and enforcement.
- ◦Ensure continuous and broad-based prevention activities that are balanced both geographically and among the diverse cultural groups throughout the county and that are responsive to demonstrated needs.
- ◦Include a prevention component in human service programs, including treatment and enforcement.

◦ **Make funding and other policy decisions that are guided by recognition of:**

◦ The critical role of traditional, long-standing youth programs that build resiliency and protective factors by developing a positive peer culture and promoting skills and competencies useful throughout life.

◦The need to address and reduce the known risk factors which lead to use of tobacco, alcohol, and other drugs

◦The importance of reaching all cultures and language groups in the county.

◦Findings of national and local research, including the data available from the Center for Substance Abuse Research at the University of Maryland, that can be applied to the Montgomery County community.

◦The importance of ensuring that programs are sensitive to developmental stages

◦The elements required for an effective prevention program, including:

1. Needs assessment
2. Clear and measurable goals
3. Specific objectives and a time frame for achieving them
4. Identification of needed human and financial resources
5. Effective leadership
6. Implementation strategies and planned evaluations that measure relative success against predetermined objectives
7. Program revision to improve effectiveness

◦**Work toward the continuous improvement of prevention.**

- ◦Empower public employees and those on contract to the government to generate ideas to prevent the recurrence of the problems they encounter in the course of their work.
- ◦Charge management with maintaining a climate of receptivity and a process for reviewing and giving feedback on these employees' ideas.
- ◦Showcase effective government or community-based prevention programs.
- ◦Publicly recognize individuals and agencies that have made a difference in prevention activities.
- ◦Support the development of effective evaluation methods where they do not currently exist.
- ◦Seek alternative funding from foundations, Federal and State grants, and other sources.

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CONCLUSION

County department heads should use this policy in their decisionmaking and budget recommendations. The policy is also intended as a set of guidelines for all county personnel and contractors.

In addition, the policy aims to provide leadership and a model for all county groups and organizations sharing a concern about the serious problems of alcohol, tobacco, and other drug abuse and their impacts.

All community groups and organizations serving children, youth, and families are invited to join this vital effort for the good of our county.

TASK FORCE MEMBERS WHO DEVELOPED AND REACHED CONSENSUS ON THE PROPOSED PUBLIC POLICY ON THE PREVENTION OF ALCOHOL, TOBACCO AND OTHER DRUG ABUSE

Officer Mary Carlin
Maryland National Park Police

Dr. Lillian Durham, Asst. Dir.
Resident Services Division
Housing Opportunities Commission

Harriett Guttenberg, Exec. Dir.
Mental Health Assoc. of Mont. Cty.

Beverly Hassell, Director
The Prevention Center

Joan D. Liversidge
Substance Abuse Coordinator
Division on Children and Youth

Scott McMillin, Director
Addiction Treatment Unit
Suburban Hospital

Robert Myers
Division of Adult Addiction Services
Dept. of Addiction, Victim,
and Mental Health Services

Laurence F. Pignone, Exec. Dir.
United Way of Montgomery County

Joan Planell
Child Welfare Division
Department of Social Services

Fr. John Powderly, Sub. Abuse Coord.
Archdiocese of Washington

Ellen Pucciarelli
Division of School Health Services
Department of Health

Lorraine A. Rogstad, Director
Child & Adolescent Services
Community Psychiatric Clinic, Inc.

Martha Rosacker, Prevention Spec.
Department of Family Resources

Rita Rumbaugh, Sub. Abuse Prev. Spec.
Montgomery County Public Schools

Carol Giannini Small, Drug Prog. Coord.
Council of Governments

Charlie Steinbraker, Committee Chair
Exec. Assistant to the Director
Department of Recreation

Officer Vincent E. Thompson, Jr.
Department of Police

Douglas Tipperman, Staff Director
Mont. County Community Partnership

Michael Ward, Director
YMCA Bethesda Youth Services

JOINING FORCES:
Montgomery County Professionals Share Their Approaches To Preventing Substance Abuse in County Communities

Thirty-five professionals from across the county met all day on May 11, 2000 to exchange information and wrestle with issues connected to preventing the abuse of alcohol, tobacco, and other drugs in county neighborhoods and communities. The goal of this diverse group was to learn more about the array of prevention programs sponsored by both public and private organizations, to find ways to build on each other's expertise and resources, and to come up with ways to raise the profile of prevention work in Montgomery County. A major point on which retreat participants agreed was that prevention of substance abuse can -- and should -- be woven into every aspect of community life: daycare, schools, libraries, health care, recreation programs, and everyday community events.

WHY WE MET:

The County's Department of Health and Human Services' office of Public Health Services is the lead agency for alcohol, tobacco, and other drug prevention work in Montgomery County. Within this agency, the Substance Abuse Prevention Coordinator is responsible for developing a shared vision across sectors of what prevention is all about, for coordinating public and private prevention initiatives, and for seeing that prevention work is measured and its outcomes chronicled. The May retreat of prevention professionals was one way to share the agency's vision of *creating healthy communities within the County by reducing the use of alcohol, tobacco, and other drugs,* and to build a broader partnership among programs to carry out this vision.

WHAT WE AGREED ON:

- *All parts of our county's society must be enlisted in prevention work* -- Since prevention of alcohol and other drug abuse includes educating the public about the dangers of substance use, providing positive alternative activities for people of all ages, and strengthening family ties and community life, almost all of the County's public and private programs need to become involved in prevention efforts. Prevention is broad-brush. It spans ages and cultures. It must infuse all segments of county life. Many public and private programs already are serving as arms of prevention, but not necessarily as conscious participants. More programs need to be helped to understand their potential role in prevention and to take on that task intentionally, consciously, in concert with others.
- *Effective prevention programs build on the ASSETS of individuals, families, and communities.* A large body of research over the past 10 years has proven that the most successful initiatives are those that spring from the strengths of the individuals at their center. Every child and adult, every family group, and every neighborhood and community has capabilities and resilience. Building on these constructive characteristics should be the hallmark of prevention programs across the county. Asset-centered, strength-based approaches must be the centerpiece of prevention, early intervention, treatment, and aftercare policy and programs.
- *Having A Shared Framework of Prevention Programs Helps Maximize Public and Private Resources* – Those attending the retreat agreed that mapping the array of prevention initiatives across the County helps each of them: 1) identify gaps in service (populations and geographic areas not yet addressed); 2) build on each other's work, materials, and approaches; 3) share program goals, measures, and outcomes; and 4) showcase to potential public and private funding sources their own effort's unique role within the context of a larger, conscious, county-wide prevention picture.

WHAT NEXT NEEDS TO BE DONE:

- *Complete Filling in the Framework of Prevention Initiatives in Montgomery County* -- Starting in 1998, the County's Substance Abuse Prevention Team (15 professionals whose projects are supported by the Department of Health and Human Service) began developing a shared *Framework of Substance Abuse Prevention Activities* that organized prevention work into three broad program categories related to its vision of building drug-free, healthy communities. At the May 2000 retreat, this Framework was significantly broadened to include many additional public and private prevention efforts supported by or ancillary to the work of retreat participants. This expanded Framework, which will continue to be augmented as new information is provided, is becoming a comprehensive description of prevention and related programs that exist across the County. It can now be used as a planning and referral tool for program leaders and it can be shared with key legislators, policymakers, and program administrators within the County who are concerned about substance use and abuse.
- *Build a Stronger Partnership Among Prevention Professionals* – This retreat was a first step in improving communication among professionals concerned with many of the same issues. With the hope that resources can be found to support action, next steps include:
  - → *Sharing the revised Framework* as it continues to be expanded to include additional projects, programs, and initiatives (Attachment 1)
  - → *Expanding the list of retreat participants* to include additional people and programs suggested by those at the retreat (Attachment 2).
  - → *Developing a prevention ListServ* to connect those involved in both public and private prevention work in Montgomery County. This ListServe would serve as a site where state-of-the-art national and local information can be posted as well as a place where professionals can pose questions to each other about conundrums they face or where they can share opportunities or approaches they feel have worth.
  - → *Develop a "business/marketing" plan for prevention work* across the county that will sharpen its focus, clarify its targets, and participants' planning be more intentional and strategic.
  - → *Update the Montgomery County Government's 1993 Policy on the Prevention of Alcohol, Tobacco, and Other Drug Abuse* to reflect the ideas and approaches put forward at the retreat.

WHO WE ARE:

Participants brought a broad array of expertise from many sectors in the county.

Children, Youth and Family Services (DHHS)
Collaboration Council for Children, Youth and Families
Drawing the Line on Underage Alcohol Use
Head Start
Housing Opportunities Commission
Latino Outreach Program, Community Ministries of Rockville
MCPS Safe and Drug Free Schools
Police Department
Public Health Services (DHHS)
Montgomery County Community Partnership
Recreation Department
School Health Services (DHHS)
Traffic Safety Task Force
Youth Service Centers

ALCOHOL, TOBACCO, AND OTHER DRUG USE (ATOD) PREVENTION
WORKSESSION PARTICIPANTS
FEBRUARY 4, 8, and 15, 2002

Facilitator: Doug Katz

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Montgomery County Public Schools

Carrie Miller
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Montgomery County Public Schools

ALCOHOL, TOBACCO, AND OTHER DRUG USE (ATOD) PREVENTION
WORKSESSION PARTICIPANTS
FEBRUARY 4, 8, and 15, 2002

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Executive Director
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Department of Health & Human Services, Children, Youth and Family Services

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Montgomery County Public Schools, MCPS Safe and Drug Free Schools

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Officer, Montgomery County Police Department
Instructor, Drug Abuse Resistance Education (DARE) Program

Carol Walsh
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Collaboration Council for Children, Youth, and Families

Mark Winans
Team Manager, Teen Programs
Department of Recreation

RESOURCE LIST

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